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# Causes and Complexities of Health Care Inequity: the Bassari of Southeastern Senegal

Joyce Vicki Millen Bendremer

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CAUSES AND COMPLEXITIES OF HEALTH CARE INEQUITY:  
THE BASSARI OF SOUTHEASTERN SENEGAL

Joyce Vicki Millen Bendremer

B.A., Tulane University, 1984

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Public Health

at

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1993



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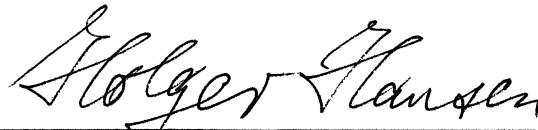
CAUSES AND COMPLEXITIES OF HEALTH CARE INEQUITY:

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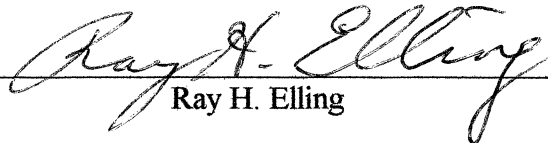
Joyce Vicki Millen Bendremer, B.A.

Major Adviser



Holger Hansen

Associate Adviser



Ray H. Elling

Associate Adviser



Judy Lewis

The University of Connecticut

1993



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## CHAPTER ONE

# Introduction

### Background

Advances in communication and transportation technologies in recent decades have created a heightened awareness of the profound disparities that exist among people, locally and globally. The disparities are especially pronounced between those who have access to resources and services needed to preserve health and those who do not. This heightened awareness has sparked important philosophical debates concerning so-called basic human or natural rights, individual versus government responsibility, health care rationing, and the ethics or feasibility of creating leveling mechanisms for health equity. Such debates are entering into the political dialogues of nations.

The 1978 World Health Organization and UNICEF sponsored international conference on primary health care in Alma-Ata was a forum for representatives of 134 governments to debate several of these philosophical questions. By the close of the conference the representatives had reached consensus on a few of the debated issues by articulating a historic global goal to attain health for all by the year 2000. The Health for All proclamation, which has since been used as an effective rallying cry to prioritize health on national agendas, was an effort to declare to governments of the world that a minimum level of good health and well being should be considered a basic human right to which every human being is entitled.

To realize the extraordinary goals outlined in the Health for All proclamation, WHO and UNICEF advocated for nations **to put the needs of the poor first**. This was to

be achieved through equity-oriented health and development strategies which focus priority on the most appropriate health interventions for the most common health problems **in communities of greatest need** (Commission on Health Research for Development 1990). These primary health care strategies were to: 1) place emphasis upon the development of low-cost preventive and curative services of scientifically proven effectiveness aimed at the most common and serious diseases; 2) incorporate the help of non-physician midlevel health personnel and village health workers in the provision of primary care services; 3) put emphasis upon the development of a system of supervision and support for primary care workers; 4) develop new forms of financing health programs, especially from the private sector; 5) encourage community involvement in the design and implementation of health programs; and 6) institutionalize evaluation and monitoring of health programs.

Fifteen years after the Health for All by the Year 2000 proclamation was announced to the world, UNICEF and WHO boast some extraordinary successes in lowering infant and child death rates, and increasing average life expectancy and the percentage of rural families with access to safe water and health services. Moreover, they proudly claim that as of 1990 the goal of 80% immunization coverage in the developing world was reached and the number of child deaths from diarrheal disease reduced by over 1 million a year (UNICEF 1993). Furthermore, in a more recent World Summit for Children many of the Health for All goals were revisited, reaffirmed and more specifically defined. The new goals to be achieved by the end of the present century include: control of the major childhood diseases; a halving of child malnutrition; a one-third reduction in

under-five death rates; a halving of maternal mortality rates; safe water and sanitation for all communities; universally available family planning services; and basic education for all children (UNICEF 1993:6). As of June 1992 most countries of the world had signed the Declaration and Plan of Action and had begun to draw up specific national programs to achieve these goals.

The subject of this study was inspired by the successes outlined above and the hopefulness of the new goals and projections the international health community now promote. It was my intention to conduct research in a country where the government was actively working toward the Health for All and Summit goals, to learn how these objectives were being translated into practice at the local level. I chose the country of Senegal in West Africa (see figure 1.1) because it had received international recognition (UNICEF 1989) for active participation in Health for All campaigns to improve the health status of the poor, and because I had several years prior experience in the country. More specifically, my goals were to examine how, and the extent to which, these programs and campaigns influenced the health care practices of members of one rural community. I chose a remote community, one that did not have a history of contact with the public health department or donor agencies, because I believed that changes in health practices could be more easily ascertained in such a setting. I also believed there would be fewer confounding variables at play in a village geographically remote from urban centers and Western influence. Therefore, due to their geographical remoteness and the fact that their public health situation had not yet been examined, I chose to study the Bassari people of southeastern Senegal.

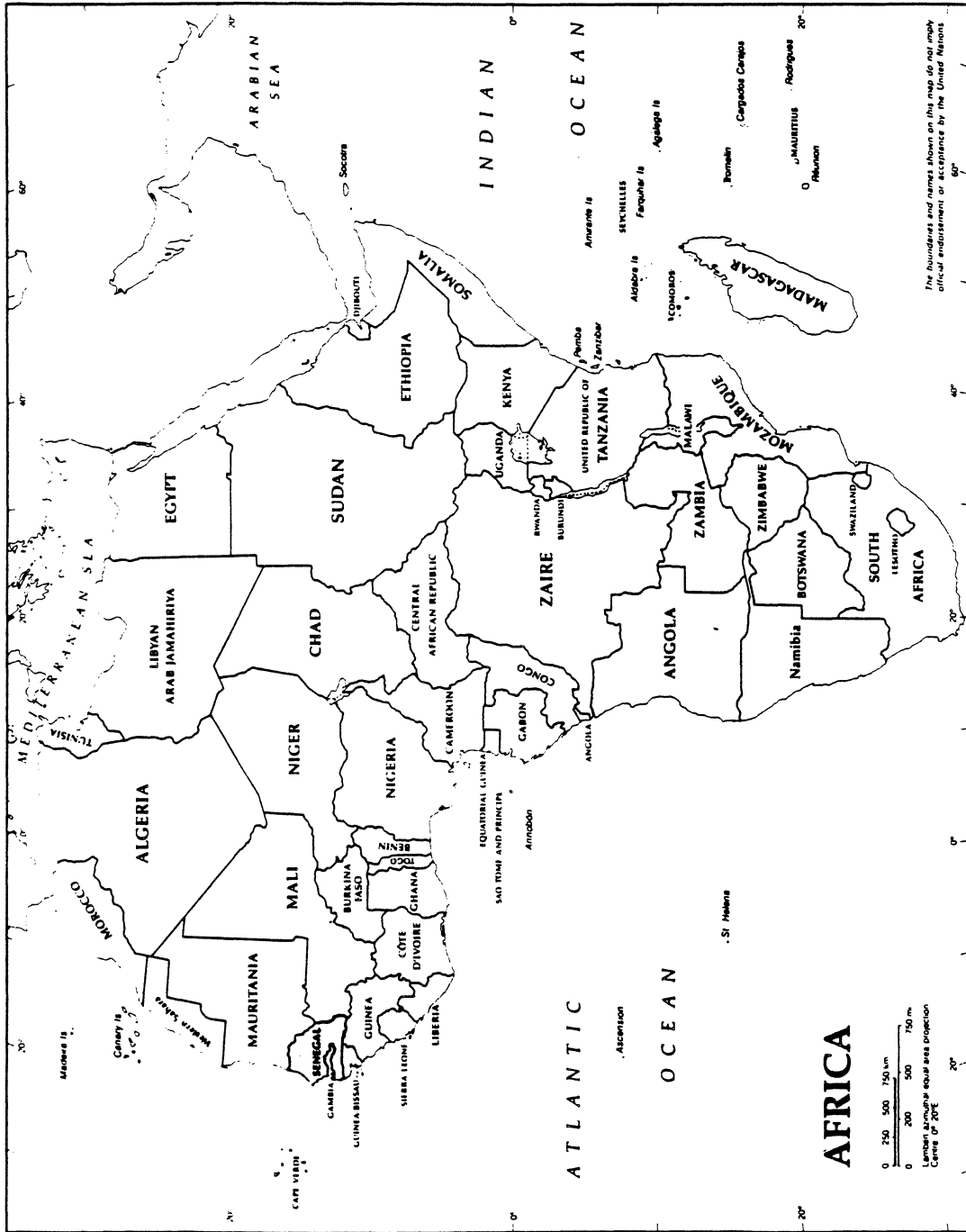


Figure 1.1 Senegal in perspective



From the government documents I reviewed and the preliminary research I conducted, I had every reason to believe that the Bassari people were, as other remote Senegalese communities, recent recipients of government water, sanitation and health projects. On paper, in government documents, this appeared to be the case. Sadly, however, it was not. As it turns out, as of May 1992, the Bassari were almost entirely cut off from the public health sector and the government of Senegal. They had received virtually none of the health or development assistance intended for the poor to realize the goals of the Summit and Health for All. Unlike every other area of the country, Bassari villages were almost entirely void of government assistance, of any kind. In Bassari villages there were: no government constructed cement lined water wells; only two government sponsored primary schools; no roads or transportation system; no government initiated village based primary health care centers, maternities, or pharmacies; no government encouraged or assisted vegetable gardening projects or income generating activities; no training, collaboration or support for indigenous healers and traditional birth attendants; and absolutely no nutrition, sanitation or health information interventions.

This stark reality forced me to alter the nature of my study, to focus more pressingly on why this particular community was either forgotten or neglected by the government of Senegal, the public health sector and the international health community. I came to question how and why this extremely poor (by Senegalese standards) community escaped the agendas of health planners whose very mission was to reach the poorest of the poor **first**? My central, fundamental question became: What are the underlying causes of health care inequity that exist between the Bassari people and the rest of Senegal? The

results, as expressed through this thesis, reveal a complex pattern of social, political and economic injustice and misrepresentation based more on history and religion than health conditions or community needs.

### **Explanation of Categories**

Examining the health situation and the healing structure of one African ethnic group poses some difficulties. In today's Africa, ethnic groups rarely, if ever, are bounded entirely to one geographical area as they perhaps were in the past. Through migration and a growing interweaving of ethnic groups, ethnic lands or boundaries are increasingly blurred. Migration from native rural villages into towns and cities has to varying degrees provided ethnic groups with changing circumstances and wider social fields of contact. Even the Bassari, despite their remoteness, participate in this general pattern of rural-urban migration (Nolan 1986). Since the 1950's Bassari men and women have been involved in various forms of seasonal and permanent migration for economic and educational purposes. And even though urban based Bassari live in different circumstances from their rural kin, their notions of health and healing, as well as their perspectives on the situation faced by their rural based Bassari families, are unique and insightful. For these reasons, I chose not to limit my study to traditional notions of "Bassariness" by incorporating only rural based Bassari individuals. Instead, I have included the entire range of residence, from Bassari individuals residing in their natal rural villages, to those who have migrated to towns and larger cities.

Related to this blurred nature of ethnic geography, therapeutic practices and treatment patterns are also not entirely distinctive. Most, if not all, African ethnic groups have had ongoing contact with other groups and as such have taken on new ideas, words, and practices from their exposure to different cultures and languages. It is not feasible, therefore, to speak of specific notions about illness, therapeutic alternatives or even patterns of treatment utilization as entirely Bassari without acknowledging the very distinct possibility that such notions or patterns may arise from varied origins. Similarly, change and time are important considerations; for what may be considered uniquely Bassari today may have been entirely foreign to the Bassari a few years prior. Therefore, while recognizing the erroneousness of ethnic boundaries, the continuum of invention through contact, the rarity of ethnic "purity," and the dynamic nature of culture, I will attempt to avoid the use of categorizations that may inaccurately reflect Bassari life. The Bassari are a remote people, but they are by no means isolated; their health situation is distinct from their neighbors and most other ethnic groups in Senegal, but their health needs are by no means unique.

### **Ambiguous Terminology**

The social and health science literature is burdened with inconsistent terminology. Often scholars make assumptions about the meaning of concepts or the operationalization of variables such as "modern" or "traditional." Moreover, with the expansion of computer generated statistics, studies are increasingly fraught with analyses and comparisons of dichotomous variables that may not accurately illustrate true ranges of responses or

continuums of ideas. For example, table 1.1 illustrates a sampling of the dichotomous variables that frequently appear in the international public health literature.

**Table 1.1: Frequently used dichotomies**

traditional	modern
indigenous	Western
faith healing	medical
spiritual	biomedical
preventive	curative
psychological	physical
rural	urban
consumer	provider
public	private

While it is difficult to avoid using such dichotomies, it is important to acknowledge that rarely do such variables exist without considerable overlap among them. Providers are also consumers of health care, urban dwellers often use "rural treatments," "traditional," or "indigenous" therapies frequently contain elements of "biomedical" or "modern" medicine and likewise in the reverse. Using such classifications without allowing for the continuum of overlapping possibilities may have unforeseen implications. By adhering too rigidly to such dichotomies, by referring to Bassari healing as "traditional," for example, it is easy to become trapped into suggesting that it is thus not modern or is in some way anachronistic. Or, because a therapy works psychologically, it can not also work physiologically, etc... Therefore, for the purposes of this thesis, I will employ "Bassari" as an adjective to describe **predominately** Bassari specific means of preventing, diagnosing

or curing illness. To describe the medicine practiced by the Catholic mission located in "Bassari country," I will use "mission medicine" and for the medicine practiced by government health employees I will use "state medicine." The rationale for differentiating between mission and state medicine will become clear in the following chapters. To simplify matters, I will use "Bassari country" as the Bassari themselves do to refer to the 100 by 30 kilometer area most densely occupied by Bassari villages.

### **Goals and Objectives of Study**

Throughout the world, public health and social science researchers have documented profound disparities between the haves and have nots of good health and adequate health care. And as is increasingly more recognized, such inequalities in health status, resources, care, and access are often strongly correlated with inequalities in income and wealth (Davis 1991, Fox 1990, Lichtenstein 1992, MacIntyre 1986, Townsend 1982). The disparities are universal and found as much between continents and nations as between socioeconomic classes, ethnic groups, households, genders and individuals. The goal of this thesis is to explore the inner dynamics of inequality by examining the existence maintenance and rationalization of health care inequity experienced by one ethnic group compared to their neighbors and the rest of the country. Specifically, I will:

- investigate and describe the instances of health care inequity experienced by the Bassari.
- critically analyze relationships between local institutions or structures and the Bassari to determine if and how such systems help sustain health care inequities between the Bassari and other ethnic groups.
- examine local ways of breaking the cycle of preventable injustices.

Often with explicit goals of bringing forth political change to reverse local or even global health inequalities, scholars have expended considerable effort describing the nature of these disparities and the social, political and economic effects they impart upon society. Yet, to date, much less research has gone beyond descriptive illustrations of injustice--to examine the processes by which local specific structures may contribute to or help sustain gaps between the haves and have nots of adequate health care. Blanket explanations, such as racism or capitalism, are often used to address why inequalities exist or are most pronounced among specific groups. However, while such overarching explanations are useful for grossly describing political and economic life and social relations, they can also mask or simplify the actual dynamics of particular situations. Thus, by presenting a profile of the health care inequity experienced between a single ethnic group and the rest of the country, this thesis will extend beyond a description of inequality into an examination of its local complexity and underlying sociopolitical context.

While focusing on a politically marginalized people, this thesis will explore the relationship between perceived local health problems and needs, and the politics of health care provision. I will begin by placing the Bassari people in their national context with a brief overview of Senegal's health situation, as compared to other African nations and the rest of the world. This will follow with a general description of the Bassari people: their environment, their history, their economy, and their political status. I will then describe the Bassari health situation, as perceived and related by the Bassari themselves, and continue by delineating the health care alternatives that are currently available in the Bassari area and to the Bassari people.

The underlying questions of health care equity will be analyzed by comparing the Bassari situation to that of other groups in Senegal. Moreover, I will analyze Bassari-specific perceptions of their health care situation with the perceptions of the public health workers and administrators who are responsible for providing services to them. Historic and political economic factors will be employed to address overarching questions of health care inequity.

My principle objectives for embarking upon this research were in concert with the underlying aims of public health. I sought to critically examine the adequacy of the public health structure in the Bassari area and, if feasible, make recommendations for change or further research. Apart from cursory references to Bassari healing practices and beliefs in French ethnographies, virtually no scholarly research had been conducted on Bassari health, in general, and public health in particular. Practically, I envision this thesis as preliminary reading for: 1) scholars who wish to further study elements of health and healing among the Bassari people; 2) local, national or international health or development workers who hope to work with the Bassari to help them more readily help themselves; and 3) the Bassari people to help them realize more solidarity so they may most effectively make their needs known and break the cycles of injustice and poverty. The above outlined goals and objectives notwithstanding, I hasten to remind readers of the preliminary nature of this study and of the very real possibility that changes have taken place since this research was conducted in 1992.

## **Health Care Equity and the Causes of Inequity in Theoretical Context**

Because the term equity has divergent meanings both within and between disciplines it is often expressed to mean one thing while understood to mean something else entirely. For this reason, this chapter will begin by exploring what is meant by equity when used in reference to health and health care services. Thereafter, health care equity will be examined in social, economic, and political contexts. To illustrate how it is applied as a goal for social justice and economic development, declarations and proposals which incorporate issues of equity will be presented. The remainder of the chapter will then focus on a broad overview of the various schools of thought concerning the causes of health care inequity and the barriers and constraints to the attainment of equity.

### **What is meant by health equity?**

An important distinction to be made is between *inequality* and *inequity*. Whereas *inequality* in health most often refers to differences or variations in a mathematical sense, *inequity* in health has a moral overtone or ethical dimension (Whitehead 1992, Smith 1993). When differences in health and health care between individuals or groups are considered unnecessary, avoidable, unfair, or unjust, these differences are thought to be inequitable. Therefore, unlike an unequal situation which simply exists in conjunction with difference or variation, a situation is deemed inequitable when various factors attributed to



it, such as its cause or manifestation, are judged to be unfair in relation to other situations in society. Of course, the judgment "unfair" must be made in culturally relative terms and will vary according to time and place as well as to focus of what is being judged (i.e. distribution of resources, accessibility of services, health outcomes). Surprisingly, because no consensus definition of health equity has emerged in the literature, researchers tend to imbue their own values into the definitions and concepts they use to describe and measure health inequities (Pereira 1993).

One criterion often used to measure notions of fairness is the degree of choice involved: "Where people have little or no choice of living and working conditions, the resulting health differences are more likely to be considered unjust than those resulting from health risks that were chosen voluntarily" (Whitehead 1992: 433). Therefore, for this criterion, equity in health implies that everyone should have a fair opportunity to attain their full health potential and that none should be disadvantaged from achieving this potential. Other conceptions of health equity formulated by economists and social scientists are variously based on notions of equality, entitlement, "decent minimum" standards, utilitarianism, maximization of the position of the least well-off (Rawlsian maxim), individual preferences, and basic capabilities (Pereira 1993). This study will utilize both the choice criterion and elements of Sen's (1980) capabilities approach, which emphasizes that "in terms of equity it is less whether a person is functioning in a certain way and more on whether that individual has the capability to do so" (Pereira 1993:40).

Before examining the causes of health care inequity it is important to clarify what is meant by health and health care needs. Unlike the distinctions that are often made

between the biomedical classification of **disease**, the social category of **sickness**, and the culturally derived notion of **illness**, the term health is multifaceted. Today health is usually considered a state of being as suggested by WHO in its holistic definition: "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (World Health Organization 1978). Yet, regardless of this holistic definition, it is frequently operationalized in research studies using one or two key indicators that are more reflective of disease than of mental or social well-being. Health is used as much to refer to individuals as to groups and its attainment is often dichotomized in terms of either having it or not having it. Of course, it would be more accurately described as a multidimensional dynamic in which individuals and groups can have varying degrees of constantly changing levels of better or worse health. Further, when the term health is employed as an adjective, such as in health indicator, health promotion, health care, health service, or health outcome, it takes on divergent meanings. Even given precise or holistic definitions, health and its component parts are constructed differently by different people depending upon a multitude of factors (e.g. age, sex, class, ethnicity, nationality, language, religion etc., )

To the detriment of the scientific endeavor, the literature rarely makes distinctions explicit when referring to health inequities. Studies tend to employ varied and inconsistent statistical indicators to operationalize health. For example, life expectancy, mortality rate, death rate, experience of illness, quality of life, and physiological indicators are all used generically to define and measure health. Different analytical tools, such as "social class"

or "socioeconomic status" are similarly employed to compare groups, map particular aspects of health, or ultimately determine where in society health inequities exist.

Depending upon one's definition of health, **health care** may be understood, constructed and measured differently as well. Generally, the medical model tends to view health care narrowly, in terms of personal medical services. However, in this thesis, health care will be understood as those things we need in order to maintain, restore, or provide functional equivalents to normal species functioning (Daniels 1983:16). In other words, health care from this perspective is by necessity multisectoral whereby the following are considered primary: adequate nutrition and shelter; clean, safe and adequate water; sanitary living and working conditions; preventive, curative, and rehabilitative therapeutic services; and social support systems.

Health **care** equity, which differs from equity based on health outcomes, refers to the equal **accessibility** of individuals or groups to health care services, or the same level and quality of health services. It is a tricky concept to calculate and although certain formulas and definitions have been proposed, many of them measure or illustrate equity in theory only. For example, some have argued that equity in access to health care services is achieved through equal expenditure per capita (Fein 1972). The health service budget of a nation or society would be allocated according to the population sizes of its regions. Of course such an arrangement would not make allowances for the differential needs (due to age, environmental variation, or social groups) of certain populations or geographical areas, and thus would certainly not be considered equitable or fair to those groups who may need more or specialized services. Neither would the other extreme which propounds

that equity in health care is achieved when groups (e.g. sociocultural, economic or geographical) attain equal health outcomes or status. Of course this is an impossible feat for health services to achieve on its own as personal medical services are only one of the elements responsible for the variation in health status found among different groups. More realistic and feasible goals for health care equity include: equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all (Whitehead 1992:434).

It is clear that health equity in general and health care equity in particular may be described, measured and analyzed in many different ways to ultimately mean very different things. No one definition exists, despite the current preeminence of the concept in the fields of public health. For this reason, and to prevent a reliance on differential assumptions about the meanings of concepts, it is important to define and clarify terms at the outset of research. The present thesis is concerned primarily with health **care** inequity versus inequitable health outcomes, though the two are often related. It will address the distribution, level and quality of health supporting/health care personnel and services related to the needs for such services among the Bassari, compared to other groups in Senegal. The term inequity is employed rather than unequal because the analysis of the data collected for this study revealed unfair and avoidable discrepancies in the provision and use of health supporting and care resources and services.

## **Health care equity as related to universal access and the Health for All 2000 Proclamation**

When the World Health Organization legitimized the concepts of equity and universal access to health care by making them international goals in the Alma Ata Declaration, it firmly responded to the age old argument as to whether good health is a human right or a privilege. According to respective political leanings and ideologies, countries still differ on this question: in some it is regarded as a human right and a public good, and in others clearly a privilege to which only those who can afford it are entitled (Daniels 1983). When health is regarded as a right "there is obviously a greater potential for equity, at least in theory" (Smith 1993: iv).

Although they are not the same concepts, the goals of equitable health care and universal access to health care are very much related. No health care system has, or can have, perfect equability in all aspects of health care. But, the one area that is the most fundamental, and perhaps the most important, is that of simple access to health care services. Most nations, especially those which are highly indebted or whose health system is controlled by a competitive market economy, cannot yet offer all of their citizens this simple guarantee. Therefore, much of the recent effort toward national and international health care reform has focused on the goals of universal access to care. When universal access to health care is achieved, when all individuals are able to utilize and be served by health care services, the belief is that more equitable health outcomes will follow (The Commission on Health Research for Development 1990, UNICEF 1993). The promotion of greater health equity was central in the ten point declaration of Health for All by the

year 2000 from the WHO and UNICEF sponsored Alma-Ata conference on primary health care in 1978. Target II reads:

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries (WHO 1978).

Health for All 2000 is a proclamation that seeks to synthesize many goals of international development and social justice, among which universal access to health care services is one of the most important. When universal access to health care services is attained, we will be closer to realizing several of the principles of health care equity. Thereafter, would be the guarantee that the same level and quality of health services were available to everyone, according to need rather than income, ethnicity, or gender, etc..

Not surprisingly, some disagree with the wording and general means laid out in the Brandt Report for attaining Health for All. In a critique of the WHO declaration, Navarro (1984) castigates the designers of the proclamation for over emphasizing and idealizing the possibilities for cooperation, sharing and collaboration in the current world system. He believes that the proclamation purposefully disregards all concepts of class and class struggle and ignores the more realistic states of conflict, exploitation and expropriation that currently mark relations among nations and groups. Navarro (1984:469) believes that the way in which the Health for All proclamation was constructed will be an impediment to the attainment of the lofty goals it promotes:

..the *real* gap is not between North and South, but between the capitalist metropolises and the dominant classes of the capitalist periphery on the one side and the impoverished population of the capitalist periphery on the other. *It is these class relations and exploitation that are at the root of underdevelopment, poverty and the disease of the majority of the world's population.* (italics in original)

## **Why and for whom is health care equity so important?**

From a humanitarian viewpoint, the case for health care equity is compelling. Theoretically most people believe that individuals, regardless of sex, age, ethnicity, religion, etc., should have the optimum **potential** to lead a healthy life. We would, therefore, not look favorably upon a society which denies certain individuals, by no choice or power of their own, access to health care services while providing the rest of society full access to such services. Even though most countries have some discriminatory elements, it is easy to condemn systems that willfully neglect segments of their population as blatantly unjust, and societies that promote such situations as inherently unfair.

From an economic standpoint, when health care use is directly related to better health status, can any society afford to let the talent and performance of segments of their population go untapped? The benefits of having a healthy and productive labor force has long been recognized. Even throughout the colonial era, core capitalist countries offered health services and conducted public health programs in periphery states to guarantee the productivity of plantation and mine workers (Brown 1978:259). More recently most countries have recognized the economic disadvantages that result from inequitable distribution, access and quality of primary health care services. When individuals do not have adequate access to health services, the resultant tendency is to postpone seeking care until a condition becomes severe and, thus, significantly more costly to resolve. Even in one of the world's most competitive, stratified and inequitable health systems, the United States, increasing segments of the population are coming to recognize and advocate for the economic advantages of universal access to health care (Aukerman 1991, Davis 1991).

When health care equity is a political goal it is most often intended to help disadvantaged people. For when one has adequate resources, in virtually any society, health care is obtainable. However, for those who do not have resources or are socially, politically, economically or geographically marginalized, health care may be difficult to get. In fact, it is often noted that where there is the least availability of health care services, the people who live in such areas are the most politically disenfranchised, tend to suffer the worst health problems and therefore are in greatest need of health services. This so-called "inverse care law" is most often related to the urban/rural divide (Hart 1971 in Whitehead 1992). Advocates for universal access to health care note that those who have little or no access are usually poorly organized rural dwellers. This fact weakens the political pressure for universal access to health care vis-à-vis that for upgrading urban based hospital facilities which improve the ability to serve a small portion of the population and illness spectrum (Green 1991: 748).

### **Causes of health care inequity and barriers to health care equity**

Because health care inequity implies a preventable situation (Whitehead 1992), most unequal health care services that are due to non-human or natural occurrences, such as circumstances arising from climatological, environmental or animal originated disturbances, would not be considered health care inequity. In contrast, causes of health care inequity may include social, cultural, economic or political factors that serve to deny certain groups (even large majority groups) or individuals of the same health care choices and capabilities enjoyed by the rest of society. This section will explore the many and



divergent causes of health care inequity and the barriers that are purposefully or inadvertently constructed to prevent the attainment of greater equity at national and international levels. Because in most, if not all, circumstances, inequity in health care is directly related to inequity in wealth, many of the following points are expanded from analyses concerned more specifically with income gaps and causes of extreme impoverishment. Even though proving causation in the environment of so many confounding variables is extremely difficult and often impossible, scholars do formulate causal hypotheses. While some seek to underscore single factors that lead to situations of inequity, many agree that health care inequity is actually caused by a combination of interrelated factors.

#### I. Inadequate or maldistributed health resources and personnel

One of the most common beliefs is that health care inequities arise from inadequate health care resources and personnel. Many believe, for example, that the great disparities in health and health care services between industrial or Western countries and developing or third world countries are due to the relative priority nations place upon health care in their national budgets. In theory, the greater percentage of national budget a nation chooses to (or is able to) allocate to health, or the more per capita money expended on health services, the greater the level of health will be realized by the population.

Every year in the UNICEF published document, The State of the World's Children, the percentage of central government expenditures allocated to health is recorded for each country of the world. The 1989 report explained that in the 37 poorest nations of the world, spending per head on health was reduced by 50% over the previous few years.

In Senegal, the expenditures on health as a percentage of total government expenditures plummeted from 5.9% in the late 1970's to 3.3% in the late 1980's (Ogbu 1992). Recently, decreasing average incomes, a grossly deteriorating debt-service ratio, and increasingly rigorous international structural adjustment policies have accounted for these drastic cuts in per capita health spending. Yet, supporters of the "inadequate health expenses view" ask why health spending is so often the first and easiest target for cuts under conditions of budgetary constraints. They point to an assumed causal link between the amount of public expenditures and the quality and quantity of health care delivery and health outcomes (Chernomas 1990, Dunlop 1983).

However, when closely scrutinized it becomes apparent that there is only a nominal connection between healthy outcomes and the amount a nation expends on health in a given year, measured either in percentage of national budget or per capita (Ogbu 1992). The link is too simplistic and does not account for changes in expenditures over time or the state of infrastructure already in place. For example, in the current UNICEF (1993) report there appears to be little or no correlation between the percentage of national budget allocated to health and the level of health of a nation's people, measured by the rate of under five infant mortality. In fact, the country with the lowest rate of infant mortality, Sweden, expended among the lowest percentages of national budget on health, a mere one percent. In another example Caldwell (1993) explains that "in 1988 Sri Lanka spent 1.7% of its GNP or \$7 per head on health and provided one doctor per 5520 persons in order to achieve a life expectancy of 71 years, while Iraq spent 4.6% of its GNP or \$123 per head and provided one doctor per 1740 persons to achieve a life expectancy

of 64 years." Nonetheless, development organizations and international agencies, such as the United Nations Development Program, still advocate a minimum level of 20% government expenditure for health and health supporting services (United Nations Development Program 1992, UNICEF 1993). Rather than examining the specifics of each country and making recommendations more reflective of the degree of its indebtedness and the relative worth of its currency accounting for inflation, the recommendation makes a gross generalization that 20% of national budgets should be targeted to health and health supporting expenditures. Further, the recommendation says little about the way this 20% should be spent and distributed.

Maldistribution of health related resources and personnel is another means of creating inequities. This can be analyzed in terms of location, whereby more and better resources and personnel tend to be concentrated in urban centers, despite the fact that the vast majority of most nation's populations reside in rural areas. This scenario is quite common in African countries where politicians either rely on urban elites for political support or are continually in need of appeasing powerful and organized urban based worker and student organizations (Feierman and Janzen 1992, Moussaye and Jacquemot 1993). This appeasement often comes in the form of guaranteeing quality health care services to urban residents at the very expense of the rural, less influential, majority. Commenting on the discrepancies between African capital cities and their surrounding areas, two scholars noted that in West Africa one is stunned by the disparity between the concentration of resources in the capital cities and the neglect that is the fate of much of their hinterlands (Gugber and Flanagan 1978 in Pearce 1992). For example, in Senegal in

1980, the region of Dakar (the capital), home to 30% of the population of the country, absorbed 60% of the national budget for medication, 70% of the physicians and 60% of the trained midwives (UNICEF 1989a).

Maldistribution of resources also occurs when certain groups, such as age groups, genders, dominant ethnic groups, or economic elites, through politics or other, receive a lion's share of health supporting services, research dollars, or preventive and curative health care. This maldistribution can be purposeful and direct, as in countries whose political structure is based on segretory and discriminatory policies, such in an apartheid state. In South Africa, for example, Packard (1989) documents the effects of so-called "apartheid medicine" and "sanitary segregation" on black populations during serious outbreaks of tuberculosis. Yet maldistribution of health resources is more often inadvertent and indirect, whereby widely accepted, albeit discriminatory, ideologies (i.e. concerning justice or the role of the individual versus the state) permeate and influence health policy and the allocation of resources (Bayer 1983).

The maldistribution of personnel, usually translated into concentrated pockets of physicians and nurses in urban centers, is highly common in most African countries today. For example, in the Ogun State of Nigeria where the doctor/patient relationship in the capital city was 1:11,245, the adjacent rural area counted one doctor per 192,615 people (Pearce 1992). This scenario, repeated countless times throughout the continent, vividly illustrates a conspicuous aspect of health care inequity.

## II. Ideological frameworks for social relationships and organizations

It has been argued that the maldistribution of health resources is simply a condition

or symptom of a much more profound cause of inequity. This underlying cause is the sociocultural value structure and belief system; the religious, political, and economic ideologies that are shared by individuals in positions of power. These beliefs ultimately structure the laws, policies, and institutions that are necessary for the operation of society. They similarly determine how social relationships and organizations are created and supported, and they provide maintenance for a status quo that protects the interests and holdings of the most powerful groups. Advocates of this theory have a plethora of illustrations from which to build their case.

According to this theoretical perspective, persistent disparities between the health of different groups can be explained through an understanding of the underlying ideologies of dominant groups. Sexism is one such underlying ideology thought to create health inequities. In many nations discriminatory or unjust laws that serve to lower the status and health of women continue to be passed. Economic and political discrimination create health inequities between men and women, as does discrimination within marriages and family. Even when harmful and discriminatory practices are illegal or officially discredited, beliefs and traditions are often so strong that harmful practices continue to flourish at local levels.

In a publication entitled Women: Challenges to the Year 2000 the paradoxical state of women's health is considered: "Even though women are the main providers and brokers of family and community health, largely as a result of preexisting inequalities, their own health needs are almost everywhere inadequately addressed" (United Nations 1991). In many societies of South Asia, China and certain Arab States, boys are more valued than

girls. In terms of health such a preference is reflected in various health and health service indicators. In societies where more value is placed upon boy children than girl children, the latter are more likely to be affected by reduced access to health care. Moreover, in such countries infant and child mortality rates are higher for girls than for boys, even among wealthier families. In Bangladesh, for example, girls have a 70 percent higher mortality rate than boys. Research studies have also demonstrated that in some countries girls are less likely to be taken to hospitals than boys; the quantity and quality of food is unequally distributed in favor of boys and male adults; and female infanticide, bride-burning and dowry deaths are common (United Nations 1991).

Another underlying ideology that engenders health inequity is racism. In the United States, for example, institutional racism is often cited as a cause of chronic health inequity between black and white Americans. In fact, many studies have documented the chronic and currently growing gaps in health outcomes and access to health services between black and white Americans. For example, in 1988 life expectancy at birth was 75.5 years for whites, but only 69.5 for blacks (U.S. Department of Health and Human Services 1989 in Navarro 1991). In 1989, black Americans continue to have a  $1\frac{1}{2}$  times higher death rate than whites of the same age, and the infant mortality rate for blacks is twice that of whites. It has also been determined that "not only are there differences in access, but the care provided differs for blacks and whites along a number of dimensions (Blendon, et al 1989). Given such blatant health and health care differentials between races, it is not unreasonable to blame such inequities on deep rooted racist paradigms that develop into institutionalized racism (Reed 1990). Thus, in order to close the health gaps between races, adherents of this view consider improvements in race relations to be crucial.

The theory maintains that whites have in a sense gained economic advantage from their exploitation of blacks, that whites are indeed better off because blacks are worse off. From an article published in the Milbank Quarterly the author asserts, "Often, whites do not accept the changes that would make life different for blacks. We are often unwilling to inconvenience or burden ourselves to facilitate the entrance of blacks into the mainstream. Partly, it is because of the fear of job competition or increased taxes" (Miller 1987:526). The implication of this message is that whites must come to grips with and transform their intolerance or indifference by challenging the historical assumptions that help justify unjust policies. Ultimately, this theory holds that the dominant or most powerful groups must change their moral values and institutions in order to end the discrimination (Navarro 1989).

### III. Choice of political and health system: social class as cause of inequity

Some argue that despite such inequities between races we cannot, and should not, attribute all health disparities entirely to race or racist ideology (Navarro 1989, 1991; Syme and Berkman 1990). The claim is that too much vigilance in reducing morbidity and mortality differentials between races can, and has, overshadowed the more fundamental indicator of health inequity, which is really social class. In fact, in study after study in which differentials were analyzed either for specific health problems (e.g. hypertension, schizophrenia, tuberculosis) or for general morbidity and mortality indicators, persons in lower class groups consistently fared worse than those from higher social classes (Syme and Berkman 1991). This view holds that while social class, which is most often measured in terms of occupation, education, and/or income, is probably not the only factor that

causes health inequity, it is certainly a crucial one and should not be ignored. Navarro (1991:230) notes, "The United States is the only major industrialized nation that, besides not regularly collecting mortality statistics by class, does not establish as one of its top objectives the reduction of mortality differentials among classes. In the United States, race is used as a substitute for class." Ultimately, advocates of this perspective believe that class differentials are greater than other differentials (such as race, sex, ethnicity) and that to combat health and health care inequity we must initiate "a massive assault on material deprivation" (Townsend 1990). This might require: 1) drastically improving the conditions of the lower classes, through various means including radical redistribution of resources to those on low incomes; 2) creating overarching improvements in the education of lower classes, including technical skills training; and 3) increasing worker participation in unions. Of course, advocates of this view maintain that the most productive way to achieve greater equity in accessibility is to reform health care systems away from market-orientation toward socialist-orientation (Cereseto and Waitzkin 1986; Davis 1991; Elling 1981, 1989; Townsend 1990; Waitzkin 1983). Where private enterprise and market competition reign over health care systems, huge pockets of the population (e.g. 37 million uninsured in the United States) may have no, or very little, access to health care services. By contrast, in socialist oriented systems health care is designed to be universally attainable:

In the former Soviet Union and the socialist countries of Eastern Europe, as well in Cuba and in other Marxist-oriented countries in Africa and Asia, there was an ideological commitment to equity in accessibility, with a major emphasis on prevention. Health care was viewed as social responsibility (Smith 1993).



Adherents of this perspective believe that it is mostly in countries, such as the United States, that have market-oriented health systems, weak workers' movements and decentralized, fractionated authority structures (Elling 1993), that social class may be a much more telling cause of widespread health inequity. This view places the greatest burden of blame for such inequities on the level and intensity of class struggle within a nation state and the relative willingness of governments to "enable" the poor and most disadvantaged classes in society to improve their lot. When the very structure of a nation creates and protects gross wealth inequalities between, for example, working and ruling classes, then the lower classes will have less access to health and lower health outcomes. Those who believe that social class is a key indicator of health inequity note that "a vast body of evidence has shown consistently that those in the lower classes have higher mortality, morbidity, and disability rates" (Syme and Berkman 1990).

#### IV. Global political economic system

Very much related to the previous perspective is the belief that individual nations, especially periphery or so-called third world nations, are not entirely free or able to design and implement their own health agendas and policies. Rather, due to "unplanned forces such as the market and the struggle of classes within a worldwide political economic system" certain individuals, groups and entire nation states are held hostage to substandard living and working conditions (Elling 1993:4). In other words extensive health inequity between nations and groups is the result of international capital class interests which protect the needs of the elite classes often at the very expense of the working classes. As Elling (1993:13) explains "Core capitalist nations, through the agency of increasingly

mammoth meta-national corporations act as veritable vacuum cleaners sucking out the surplus produced by the working and peasant classes in the peripheral and semi-peripheral nations, so as to yield the more favorable life conditions of the core nations." It has even been suggested that meta-national corporations or multinationals now exercise increasing power which is "often beyond that of sovereign nations; and it is averred by some spokesmen that the integrity and the power of intervention by the nation state in its own affairs will soon disappear" (Smith 1993). One of the means by which this process generates itself is through what Gramsci (1972) called cultural hegemony. It is an all pervasive, often subconscious, social manipulation "felt at the most subtle levels of human interaction and the social self" (Elling 1989:212). Racism, sexism and ethnocentrism are elements of this hegemony which serve to divide potentially powerful groups so that they may not wield any control over the means of production. The hegemony of ruling capitalist classes defines our values, helps us justify discriminatory policies, and enables us to rationalize injustices such as widespread health inequity.

Other more graphic ways in which the global political economic system contributes to health inequities involves international loans, national vested interests and political maneuvering. To help improve their economies, most of the poorest nations, over the last decade and a half, have taken out large loans from the International Monetary Fund and the World Bank. These loans, under the rubric of structural adjustment programs, most often come with restrictions on expenditures for social programs, including health care (Kanji et al 1991, Korte 1992, Ogbu 1992, Social Science and Medicine 1993). Consequently, when less money is available for health care, the poorest of the poor usually

bear the greatest burden of the loss, and the greater the health care inequity inevitably ensues (Van der Geest 1992). As Kanji et al (1991) suggest, "Structural adjustment programs serve to exacerbate inequalities and threaten to reverse the social gains of the majority achieved through the struggle for independence, in the interest of the indigenous capitalist class."

Additionally, as Linsenmeyer (1989) demonstrates using the case of Nicaragua, the purely political economic vested interests of powerful nations can quite literally destroy the hopes and efforts of less powerful nations. By backing the anti-Sandinista contra movement and exerting its pressure on international loaning agencies to decline aid to Nicaragua, the United States and several other nations undermined all efforts the Sandinistas had initiated to improve their national health care system and achieve health care equity. In fact, it is not surprising that most bilateral and multilateral military or economic actions (e.g. sanctions, embargoes, financial recriminations) have the great potential of offsetting preexisting balances between the haves and have nots. Unfortunately, such actions tend to increase health inequities because they most adversely affect the poor and most underprivileged members of society.

#### V. National level conflict, bureaucracy and politics

This view faults individual nation states for their inability to design and/or implement health policies that promote health care equity. Some claim that the bureaucratic process itself acts as an impediment to the universal provision of basic health services (Justice 1987). When health policies are designed at the national (or even international) level, they are often unreflective of the true needs of those most in need of

services, such as the urban poor and rural farmers. Sometimes they are created with the best of intentions, but due to myriad factors (budgetary constraints, personnel problems, bureaucratic translation, unpredicted local realities, etc.) are not implemented satisfactorily. For example, due to chronic budgetary constraints, health services are not adequately regulated and health workers are not supervised or held accountable for their actions. Moreover, governmental policies are frequently more responsive to the demands of powerful medical professionals than the needs of less mobilized, less visible groups (Green 1991). This is because in countries experiencing high rates of unemployment, government bureaucrats may be more concerned with protecting their own jobs and positions than acting in the best interests of powerless constituents.

Alternatively, the nation state is blamed for health inequity when it cannot adequately enforce its political power. If a country does not have either a strong and cohesive state apparatus or a broad base of popular support, it cannot enforce its own laws or even control its own bureaucrats (Decosas 1990). Therefore, even when health policies are designed to be equitably distributed and fair to everyone, if the government wields no political power they will be difficult to enforce. Other governments may have sufficient political power to enforce policies, but may lack the political will to design clear and progressive national health policies. Still other governments may have both the power and the will to create and implement equity oriented health policies, but lack the willingness to coordinate multi-sectoral efforts (e.g. with education, sanitation, food security, and water) to truly improve the health of their population.

## VI. Historical and current contact with others

Some scholars trace the gross health inequities and problems currently facing most peripheral world nations to health and development policies that were created during the colonial era. Kanji et al (1991) propose, "the nature of the economic crisis in sub-Saharan Africa cannot be understood outside the context of the legacy of colonialism and class formation." In Africa, most of the colonial agricultural and economic policies, such as cash cropping, mining, forced labor and the appropriation of lands, significantly altered indigenous subsistence patterns and strategies. They severely ruptured the control and power indigenous populations had over their economic, agricultural, familial and political systems (Rodney 1983). As a result, "the colonial period was marked by increased deterioration in the health of large segments of the African population (Pearce 1992).

The colonial endeavor in Africa, as elsewhere, was mostly concerned with making profits, or at the very least extracting enough funds to cover the expenses of overseas war efforts and the administrative costs of ruling the colonies. Therefore, the objectives of the colonial health care policy were first and foremost to protect the European officials who ran the colonies, and only secondly provide services to non-official Europeans who engaged in trade or production (Stock and Anyinam 1992). As noted previously, to enhance labor productivity, basic colonial health services did extend to the "natives" who worked in areas of economic production such as in mining areas or export crop regions. However, despite the heightened needs of rural inhabitants who were adversely affected by colonial endeavors "government health services came quite late (after World War II) to African women and children, and to the rural population" (Feierman and Janzen 1992).

The rural areas that were not centers of colonial economic activities suffered from the forced labor migration of large numbers of men and the involuntary displacement of villages onto less agriculturally viable lands. The vast majority of all colonial health services were urban based and dedicated to serving the needs of the Europeans. These health care systems were based upon Western biomedical models that tended to focus more attention on curative rather than preventive services.

When independence was achieved, most of the ex-colonies wanted to improve their health services and make them more widely available. However, because a health infrastructure had already been laid and the newly independent countries seriously lacked indigenous physicians and health policy experts, many African governments opted for expediency and adhered to the colonial health practices. The newly independent countries quickly began to prioritize the training of indigenous physicians, yet, in order to do so, they soon discovered, they had to rely on Western medical personnel:

Often established as foreign aid projects, national teaching hospitals were designed to reproduce the technical medicine of the industrialized countries, rather than to address as a primary concern the most urgent indigenous health problems. These 'disease palace' teaching hospitals served to perpetuate the curative, urban, and hierarchical characteristics of colonial health care systems. They also severely distorted national budgets: J.F. Kennedy Hospital in Monrovia, for example, takes some 45% of Liberia's expenditure on health care (Stock and Anyinam 1992).

Even after colonialism, the often well intentioned efforts of international (mostly industrialized nations) development projects and campaigns continue to disturb the preexisting order and lead to dramatic increases in disease rates and health inequities. Development policies designed to bring about improvements in local hydrology,

vegetation and settlement patterns or even to reduce particular diseases, have frequently led to quite different effects due to the unforeseen consequences of altering local cultures and balanced ecosystems (Bodley 1990). Many case studies have been written documenting the deleterious health effects of hastily designed and implemented "development" projects (Hughes and Hunter 1971). Ultimately, adherents of this perspective believe that as long as African countries continue to rely on the ex-colonial nations, through development projects or so-called neocolonial ventures, the longer they will have to endure severe health problems and inequities.

VII. The cycle of poverty: lack of education, inadequate community involvement, etc.

Many development workers and international aid donors believe that the most shameful gaps between the poor and the wealthy and between those who have access to health care and those who do not are due largely to the cycle of poverty. As the UNICEF produced document, The State of the World's Children (1993) explains:

...one of the most intractable causes of poverty is the fact that the children of the poor do not usually receive the kind of start in life which will enable them to take advantage of the opportunities that do become available. And one of the main aims of development must be to break into this insidious 'inner cycle' of malnutrition and disease leading to poor mental and physical growth; leading to poor performance at school and at work; leading to reduced adult capacity for earning an income, initiating change, responding to new opportunities; leading to poor and often large families which are vulnerable to the malnutrition and disease that close the cycle and allow the current of poverty to flow from one generation to the next (UNICEF 1993: 14).

While this view acknowledges some validity in the perspectives of world system political economists who argue that exploitive economic relationships create and sustain extreme wealth gaps, it disagrees with the notion that only deep rooted, global, structural

change will enable the vast numbers of poor and suffering people an opportunity to escape their plight. Rather, advocates of this view believe that illness, malnutrition, poor growth and illiteracy are some of the most fundamental causes as well as some of the most severe symptoms of poverty and inequity (UNICEF 1993). They, therefore, believe that targeted interventions, such as health, health education and literacy campaigns can ultimately free people from the cycle of poverty and enable them to change their life circumstances. If individuals were healthier and less oppressed from malnutrition they could presumably join forces with their neighbors and mobilize enough political pressure to make their needs known. Theoretically, these efforts would ultimately serve to decrease health inequities as those at the bottom would become more involved with the planning and decision making in their own communities. Eventually the poor would bring themselves closer to those who have good health and adequate health care services.

#### VIII. Geographical and environmental factors

Apart from the non human factors (i.e. natural disasters) that create situations of health care inequity, many human made geographic and environmental factors can lead to health care inequities. When extensive rural to urban migration creates either crowd conditions in cities and/or labor deficits on farms, health inequities will result and endure unless governments can effectively redistribute resources or otherwise restructure health care systems to meet the changing needs. Similarly, development projects or other human activities (e.g. overgrazing, over hunting) can inadvertently create or intensify environmental changes such as erosion, floods, desertification, or fires that will generate new health care needs and aggravate attempts to achieve health care equity.



### **Macro to Micro Linkages**

Although the above outlined causes of health care inequity are artificially delineated, and leave the erroneous impression of being distinct as opposed to interrelated categories, they do emphasize the great diversity of opinion on the subject. Of course, the many and varied causes of health care inequity represent the many and varied solutions that have been theorized and applied toward creating greater health equity. In other words, the solutions are reflective of the theorized causes. Therefore, because many hypotheses concerning the causes of health inequity are developed at macro levels of analysis, as evidenced by the above list, many solutions are designed to address these macro processes. When the belief is, for example, that national level politics or global exploitive economic relations are the underlying causes of preventable and unjust health inequalities, solutions are designed at the national and international levels. Market relations and capitalism, class struggle and hegemonic processes, labor laws and workers movements, national level politics and policies, ministry regulations and decisions, international and national resource allocation and distribution, and international trade and tariff agreements-- all become targets for reform in the quest for greater health equity. Alternatively, when individual behavior, cultural systems, community action or inaction, or the cycle of poverty are thought to be direct causes of health inequity, the solutions are targeted more toward changing individual behavior or circumstances through immunization campaigns, literacy programs and health education at the micro level.

Usually, the causes of inequity and the solutions to grossly inequitable situations are conceptualized on one or the other, macro or micro levels. Either changes occur and

must be resolved at the macrostructural (international or national levels), or at the individual agent (cultural and behavioral) level. Of course, there exists an enormous middle ground of intermediate level administrators and technicians who usually have powerful influence in mediating macrolevel policies and processes "down" to local levels (Pelto and DeWalt 1985). While it is certainly feasible that the activities and work of the provincial, departmental, or regional level administrative offices may cause or accentuate health care inequities, this level is rarely considered.

Perhaps the intermediate level is not examined because academic disciplines tend to be either local level/ individual focused or global/national focused in theoretical orientation, and therefore research is similarly divided. Or, scholars may ignore this level because they do not credit the offices and the functionaries of the intermediate level with enough decision making power to make a difference. Middle level workers may not be acknowledged in studies because they are viewed as simple implementors or technicians, responsible for carrying out policies that were created without their input at higher administrative levels. Whatever the reasons, this thesis will demonstrate that intermediate level administrative systems can be considerable alleviators or contributors to health care inequity. Moreover, to comprehend how and the extent to which macro level processes impact micro level systems, it is crucial to examine the channels through which policies go. How are policies and regulations translated into action or reconfigured to correspond to local level realities?

Similarly, when injustices, such as health care inequities, are recognized at local levels, it is important to understand the amount of will and power mid level functionaries

are able to exert in their localities to ameliorate such problems. This is important because, as this thesis will demonstrate, some local level structures, patterns or circumstances actually heighten health care inequities. So, whereas macro level causes of health care disparities appear almost insurmountable from local levels, the causes of health care inequity that originate from local levels often can be adjusted.

In conclusion, this chapter has explained health and health care equity and delineated, albeit in simplified form, many of the theoretical perspectives that address the underlying causes of health care inequity in the world and within nations. Most of the perspectives place the burden of blame on very abstracted levels of analysis, such as international political economic systems or national ideologies. Therefore, their solutions to the injustices of health care inequity are similarly abstracted, and too depersonalized to attract the wide popular support they would need to have an impact. However, as this thesis seeks to demonstrate, simply because a problem, such as health inequity, originates at the national or international level, does not mean that: 1) it is manifest similarly in every region; 2) that it cannot be prevented or averted from descending down to local levels; and 3) that there aren't ways of minimizing its impact on local populations. Current trends in the Indian State of Kerala help to illustrate these points. Despite the impoverishment of much of the population, socialist-oriented government and wide community based participation in decision making have contributed to a substantial close in the health inequity gaps between groups. In fact, the level of health care **equity** in Kerala State is virtually unprecedented in India. (Ratcliffe 1978, Panikar 1984 in Elling -in press). The situation facing the Bassari of southeastern Senegal will further illustrate these points.

## **Research Design and Methods**

In the previous chapters the underlying goals of this research were suggested: 1) to describe and investigate the instances of health care inequity facing the Bassari; 2) to critically analyze local institutions, structures, or systems which help sustain health care inequities in that community; and 3) to examine local ways of breaking the cycle of preventable injustices. To achieve these goals, this research was designed to integrate many different sources and levels of information. Both qualitative and quantitative data collection techniques were employed to investigate the complexities of Bassari health seeking practices, and the processes through which health providers delivered services to them. Because no previous research had been conducted on Bassari health care and because of the short duration of the research, this study was designed to be exploratory and preliminary. It was also designed to provide preliminary baseline data for future scholars who may choose to conduct comparative or impact studies in the Bassari area.

As noted previously, the study was undertaken among the Bassari of southeastern Senegal between January and May 1992. The Bassari were chosen as the research population because of their minority status and their geographical remoteness. The data gathering methods used included: key informant and in-depth interviewing, participant observation, structured questionnaires, and archival research. The data were gathered in two phases over four months.

The first phase was designed to collect data from individuals and organizations (governmental and private) charged with providing health care services to the Bassari. This phase of the research required a considerable amount of traveling. I began by investigating how national, regional, departmental and district level health policy makers, educators, and providers (none of whom were Bassari) perceived the social and health situation in the Bassari area. Concurrently, I reviewed ministry of health and public health agency reports and documents to examine how the Bassari and their health situation were portrayed to, and by, administrators and policy makers. I also interviewed representatives of the international health and development community who were working in the region within which Bassari country is located. At each of the four Senegalese administrative levels, from the nation's capital to the Bassari district, at least two representatives of the ministry of health were interviewed. Only individuals who presumably had the Bassari area under their geographic jurisdiction were included and, although I did not have total control over who was interviewed, I was able to guarantee that a diversity of health specialists were represented in the sample. In Bassari country I interviewed the one health care worker who provided health services to the Bassari, a Swiss Catholic nurse who had worked at the same mission since the early 1980's. I also spent two days *en tourné* with the mission nurse as she made visits to distant Bassari villages. All of the interviews conducted with health officials and providers were in French and most were tape recorded and later transcribed.

The second phase of the study was ethnographic in nature and was conducted entirely with Bassari individuals. During this phase I based myself out of the small, remote

arrondissement (district) capital of Bassari country, Salemata. This arrondissement capital, like many in Senegal, had only minimal radio communication with the rest of the country, no electricity and no functioning well system for running water. It was, however, well situated to access other Bassari villages by foot. The Bassari interviews were conducted in four widely dispersed rural villages, one departmental capital, and the closest regional capital. Because no roads or public transportation connect the Bassari villages, I confined the investigation to four villages that were within a days walk from one another. Although the selected villages were themselves remote and virtually void of western made goods, apart from clothing donated by the missionaries, it should be noted that they were among the least remote of the Bassari villages. Consequently, given this sample of villages, my findings have a conservative bias. Most Bassari villages were, in fact, situated much farther (up to 60 kilometers) from the arrondissement capital and their health care situations were likely much worse than what I witnessed in the less remote villages.

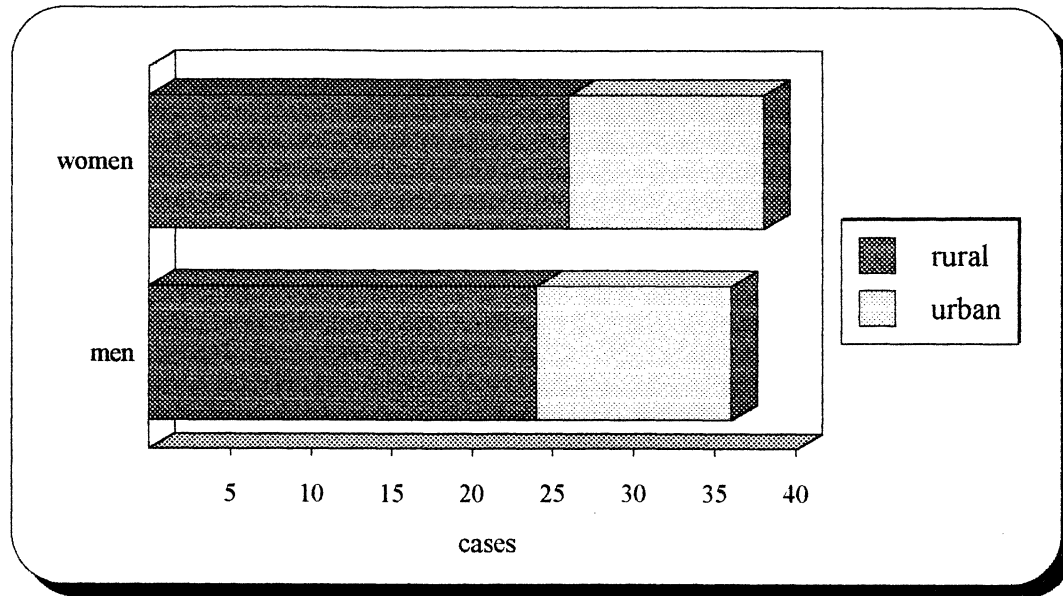
I conducted fifty in-depth, partially open-ended structured interviews (at least one hour each) in the rural villages: twelve in each of the four selected villages and two from nearby villages. Twenty-four one hour in-depth interviews were also collected from Bassari migrants who reside in the closest departmental and regional capitals to Bassari country. Efforts were made to recruit equal representation from both sexes and Bassari age groups, and to incorporate the existing range of education, religion and migration histories within the sample population (see figures 3.1, 3.2, 3.3, 3.4, 3.5). The initial interviewees were selected randomly either from public gatherings, in the fields, or at their

homes. The last interviewees were found in the same manner, yet they were selected according to the distribution of variables already represented in the sample.

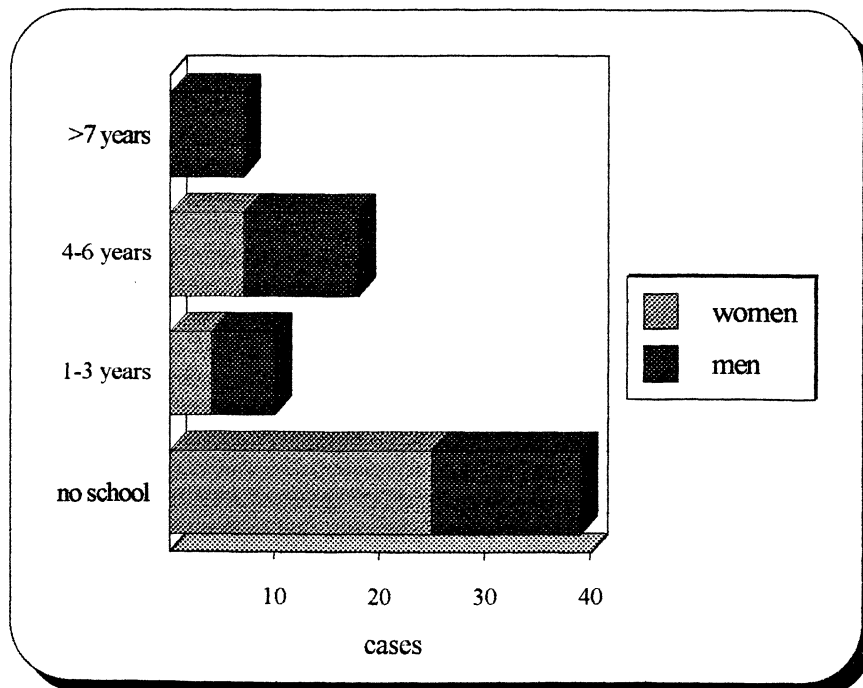
For the purposes of learning how the Bassari-specific health system functions and understanding the fundamentals of Bassari beliefs regarding health and healing as related to religion, I also interviewed six of the most prominent Bassari healers. These key informant interviews were entirely open ended and long, lasting from three to six hours each. To guarantee continual consistency of translation and interpretation throughout the entire second phase of the research, I worked very closely with a single French educated Bassari key informant, interpreter.

To compare the perceptions that health educators, policy planners and providers had of the Bassari situation with the perceptions the Bassari have of their own circumstances, I began by asking the same questions of each source. For example, of both health sector employees and the Bassari I asked: 1) What is the health situation of the Bassari people?; 2) What are the most prevalent illnesses among the Bassari?; 3) How would you describe the health infrastructure (modern and indigenous) in the Bassari area?; 4) What are the major public health problems faced by the Bassari?; and 5) What are some practical ways to improve the health situation of the Bassari?

**Figure 3.1**  
**Demographic distribution of Bassari interview sample by sex and residence**  
**(N = 74)**

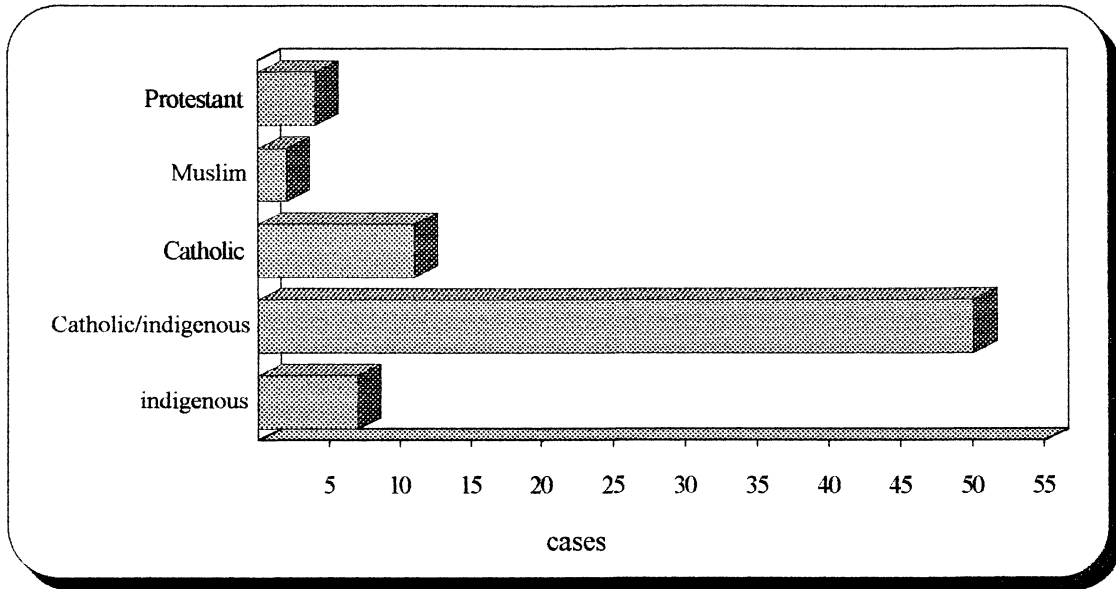


**Figure 3.2. Demographic distribution of Bassari sample by sex and years of school**  
**(N = 74)**

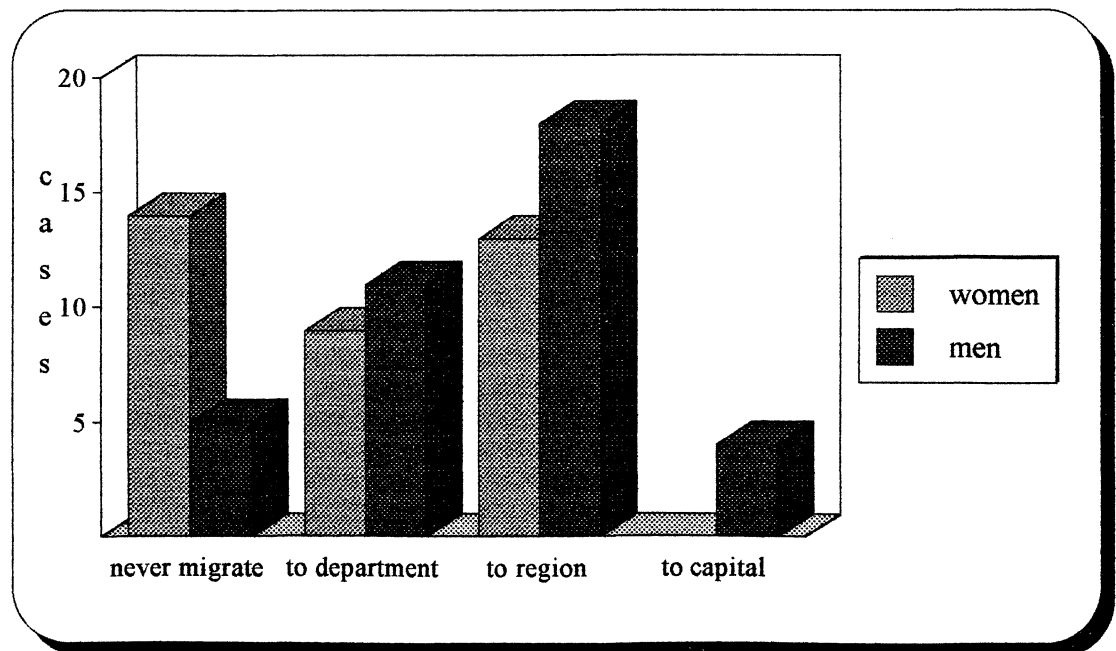




**Figure 3.3 Religious distribution of Bassari interview sample  
(N = 74)**



**Figure 3.4 Destination of longest migration, Bassari interview sample  
(N=74)**



**Table 3.1. Sources of income by gender of Bassari interview sample  
(N=74)**

<b>SOURCES OF INCOME</b>	<b>WOMEN</b>	<b>MEN</b>
farming only	15	17
farming and light commerce	7	4
farming and craft	8	11
farming and receives help from urban based relatives	1	0
farming and catechism	2	2
craft or commerce only	3	4
<b>total:</b>	<b>36</b>	<b>38</b>

## **General Background on Health in Africa and in Senegal**

To place the present study into regional context and provide background for comparison, this chapter will begin by describing the health situation in Africa as compared to the rest of the world. Then, using general social and health indicators, it will explain how Senegal's health situation compares to other African countries. Thereafter, I will provide a brief overview of current public health efforts initiated by the government of Senegal and the health ministry's ongoing work to improve the health and well being of the nation. Only by embedding this research study into such national and regional contexts can we begin to address issues of health care equity and appreciate the intricacies of the health care system of the Bassari.

### **African health situation in global perspective**

According to World Health Organization and UNICEF health and social indicators, African countries in the aggregate have the worst public health records of the seven continents of the world. In fact, of the 25 countries considered the poorest in the world (measured in terms of infant and child mortality rates) 21 of them are African (UNICEF 1993). Even compared to the least well off of all the so-called third world nations, African countries fair the worst.

In Africa only 48% of the population has access to health services as opposed to 64% in all the other third world nations. Similarly, in Africa there is one doctor for

23,000 people versus for 4,600 in the rest of the developing countries. The discrepancies in health between Africa and so-called industrialized or "developed" countries are extraordinary and seem to be ever increasing. For example, in 1960, the infant mortality rate for Ethiopia and for Senegal was 172 per 1,000 live births which was at the time 7.4 times that of Britain's infant mortality rate and 6.6 times that of the U.S.A.'s. By 1991 Ethiopia's infant mortality had dropped to 125 and Senegal's to 82. However, the discrepancy between these nations and the industrial world actually grew. In 1991 Ethiopia's infant mortality rate was 17 times that of Great Britain's and 13 times that of the U.S.A.'s while Senegal's was 12 times the rate in Great Britain and 9 times the rate in the U.S.A. These growing discrepancies between African nations and core capitalist nations are the norm rather than the exception (Pearce 1992). Furthermore, while most areas of the world continue to make progress in improving access to health care, lowering population growth, eradicating preventable diseases, and entering children into schools, most sub-Saharan African nations appear to be either stagnating on these fronts or actually getting worse (UNICEF 1993). Compared to the Middle East and North Africa, South Asia, East Asia and the Pacific and Latin America and the Caribbean, sub-Saharan Africa has the lowest life expectancy at birth, the lowest percentage of children enrolled in primary school and by far the lowest percentage of population with access to safe water or health services. An African health geographer, Iyun (1993) recently noted of African children that it is generally accepted that only about half of them will survive until their fifth birthday. He also noted that Africa remains "the continent with the shortest recent gain in longevity" (Iyun 1993:1244). Reflective of these statistics, sub-Saharan

Africa has by far the greatest percentage of people living below the absolute poverty level: 62% in rural areas. When compared to the rest of the world, the situation of health in Africa is dismal and appears to be worsening due to the world capitalist system, the IMF, multinationals, anemic economies, huge foreign debts and extensive health expenditures from the AIDS pandemic.

### **The situation of health in Senegal compared to the rest of Africa**

As is the situation between Africa and the rest of the world, great disparities exist within Africa itself. The wealthier countries of Northern and Southern Africa have better health indicators than the rest of the continent. Higher childhood mortality rates are reported in West and Central Africa compared with East and Southern Africa. More recently, the significantly higher rates of HIV infection and AIDS in Central and Eastern Africa also demonstrate extreme variations in disease patterning and epidemiology between regions. The African continent is extremely diverse socially, geographically, and environmentally, so it is no surprise that such variation occurs between regions. Yet, despite disparate health situations and indicators between regions and nations, the variation is sometimes the greatest and the most inequitable **within** nations: between the ruling classes and the ruled, between the urban elite and the rural farmers, between the educated and the preliterate, between geographical regions, and between the sexes, generations and ethnic groups.

Compared to the rest of Africa, Senegal is not extraordinary. It is certainly not the poorest nation, or the nation with the worst public health record, but it is likewise very far

from being one of the more exemplary nations. In terms of gross national product, Senegal actually appears better off than most sub-Saharan African nations. Of the 38 sub-Saharan African nations that have current statistics for per capita gross national product, Senegal ranks eighth highest with a GNP/capita of \$710 (UNICEF 1993). Unfortunately this indicator is extremely deceptive and reflects more the income inequality that exists between the urban elite and the rest of the country than any real measure of per capita income. While no current statistic exists for the average rural farmers income, the Bassari are believed to be among the very poorest in the country, with an average **annual** per capita income from \$20 to \$36 (Ministère de la Santé Publique, Département de Kedougou 1991).

In terms of health indicators, measured by the under five mortality rate, Senegal occupies a middle position: 18 countries have higher under five mortality rates and 19 countries have lower rates (UNICEF 1993). For other key indicators as well, Senegal ranks near the middle for sub-Saharan Africa: a rank which places the country among the least well off in the world. With a total population in 1991 of approximately 7.5 million, Senegal's life expectancy is 49 years, the adult literacy rate is 38% and the percentage of the population with access to safe water is 47% in the urban areas and 25% in the rural (UNICEF 1993).

One statistic that does differentiate Senegal from the rest of Africa, however, is the amount of development assistance it receives. In 1990 the Government of Senegal received 724 million dollars in official development assistance, far more in real terms and per capita than most of the 25 poorest countries of the world (UNICEF 1993). In fact,

only two countries out of twenty five of the countries with the highest under five mortality rates actually received more development assistance per capita: drought stricken Mauritania and totally impoverished Guinea Bissau.

Yet despite Senegal's relatively high per capita GNP compared to other African nations and its greater amount of official development assistance, much of rural Senegal remains without access to safe water, adequate sanitation or health services. At least two scholars (Fatton 1987, Gellar 1982) attribute the urban rural discrepancies to assymetric capital accumulation gained from international aid monies. In other words, ruling class urban elites, who share the interests and values of the donor countries, are often the greatest beneficiaries of development assistance. Their enrichment is, of course, at the expense of their rural counterparts' very struggle for survival.

### **Government of Senegal's public health structure and current goals**

Senegal is divided into nine increasingly more autonomous administrative regions. Each region is then divided into departments and departments are subsequently divided into districts (*arrondissements*). The Ministry of Public Health and Social Action follows this hierarchical structure and is currently attempting to grant greater autonomy to regional health administrators. Every region of the country now has a large government hospital and usually a smaller private clinic or military medical facility. Each region also houses representatives of most branches of the public health ministry, such as offices for health education, infectious disease eradication, etc. In addition, each department has a medical circumscription (CM). The highest medical officer of each department is called

the *medicin chef* and is also the chief physician of the CM. In most departments the *medicin chef* is the only physician available to service the entire department. In the outlying rural areas, the government has set up health posts that are run by government trained state nurses and local health volunteers. For the majority of the rural population, these health posts are usually the first point of entry into the government health system.

Since the colonial period there has been a law in Senegal, which is still on the books today, prohibiting the use of indigenous medicine (personal communication, *Medicin Chef de Fatick*). Although few people in Senegal abide by it or are even aware of it, this law was an important factor during the time of independence and the creation of the Senegalese health infrastructure. Until very recently, indigenous healers were never publicly acknowledged or assisted. Quite the contrary, in fact, they were often rendered powerless or even punished by "Western" trained health personnel. Perhaps due to a conviction of the "superior knowledge" of biomedicine or due to a feeling of competition or threat, no cooperation developed between the government health workers and the indigenous healers. As a result, much of the indigenous healing arts of the country have begun to slowly disintegrate. Consequently, because their choices became limited, people slowly came to rely more heavily on the state nurses at the health posts.

Unfortunately, the government has never been able to adequately provide for the material, training and supervisory needs of the health posts. For this reason the health posts, and the state nurses who run them, have been the recipients of many international projects to upgrade their transportation capacity, vaccination preservation materials, and medical/pharmaceutical kits. In 1989-90 the entire nation embarked upon a massive



immunization campaign to vaccinate 80% of the under five children (UNICEF document E/ICEF P/L 10. 1992). To do this UNICEF and other organizations helped the government improve the rural health infrastructure by equipping state nurses with either mopeds or motorcycles. It also provided all rural health posts with the necessary equipment to preserve and transport vaccinations. In 1992, the health posts received huge kits of medicines that were donated from a variety of organizations and countries as a result of the 1987 Bamako Initiative (UNICEF, Document E/ICEF/1988/P/L/40).

In fact, the Government of Senegal has been actively involved in most of the global health campaigns of the last decades. Directly after the close of the Alma Ata conference in 1978 the government of Senegal began to launch many new public health initiatives. It has since focused considerable political attention on establishing national goals and priorities for making health care more accessible to all its citizens (UNICEF/Dakar 1985). In the three latest five year economic plans, despite severe economic constraints, the government prioritized the expansion of health care services. Periodic drought, debt depression, international oil price hikes, decades of dependence upon France, and reliance on two highly fluctuating products of international exchange, peanuts and phosphates, have taken an extreme toll on the economic sustainability of the nation. Therefore, to help finance and implement public health initiatives, current government administrations have largely depended upon the assistance of the West and Muslim oil-producing countries. The government of Senegal invited in, and accepted assistance from, for-profit, nonprofit, governmental, non-governmental, voluntary, religious, unilateral, and multilateral development agencies and organizations. It has also

participated in most of the United Nations sponsored health programs that have been targeted to sub-Saharan Africa: such as nationwide vaccination, family planning, mother and infant nutrition, and health education campaigns. Moreover, the government has sought to create new, and upgrade old, health institutes and facilities that participate in the formation of health providers and planners. In sum, despite very serious budgetary constraints and difficult structural adjustment demands, the government of Senegal has made some major efforts toward realizing the Alma Ata goals of "Health for All by the year 2000." However, the question remains: have these efforts been designed and implemented with attention focused on "the poorest of the poor first" or with the goals of health care equity in mind? I will begin to respond to these questions in the next chapter.

## **The Remote Bassari and their Current State of Public Health**

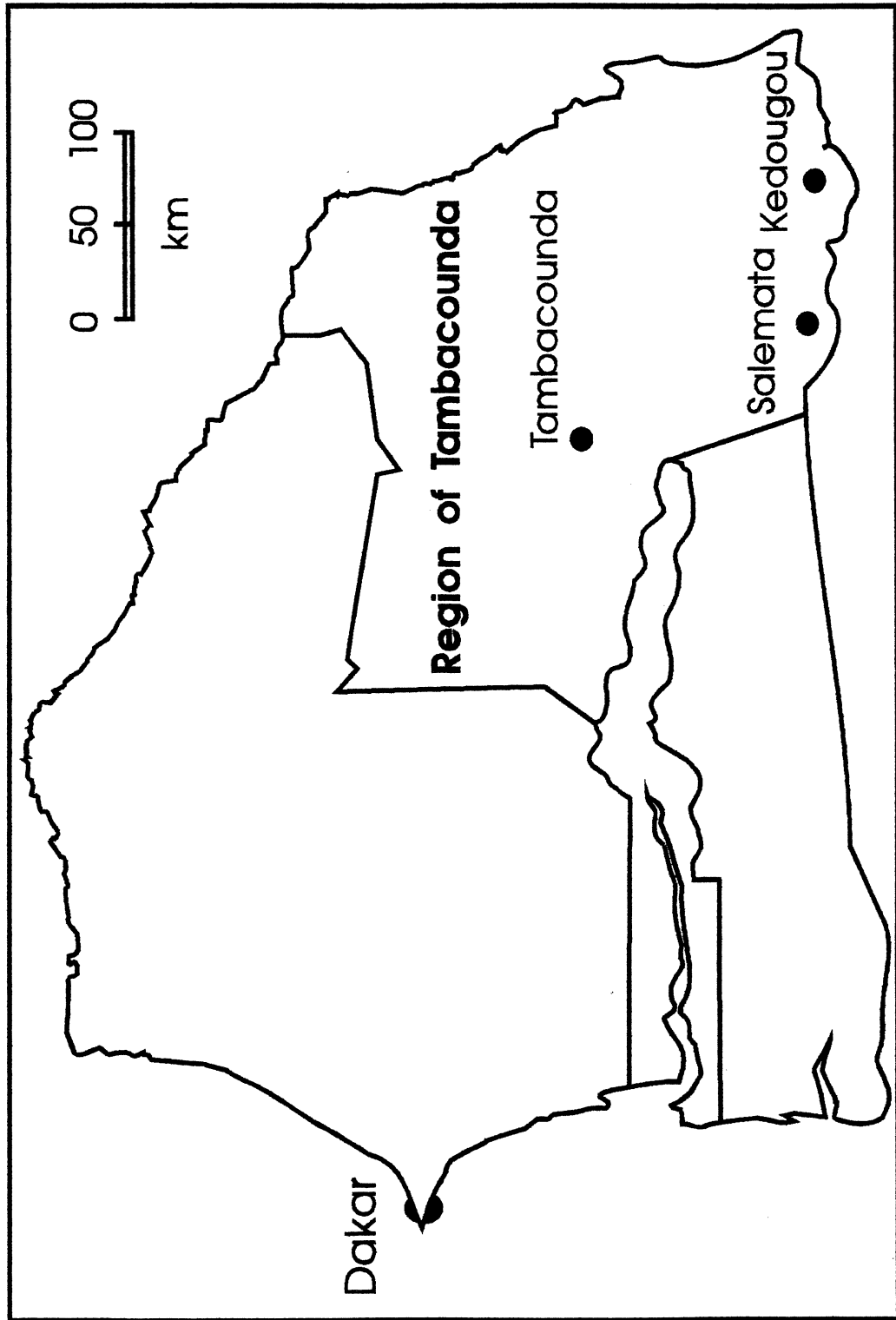
### **General Background on the Bassari**

#### Geographical situation

The Bassari are a geographically and culturally remote people. They inhabit an area of approximately 120 kilometers by 30 kilometers in southeastern Senegal and northern Guinea. In Senegal, Bassari country is situated (figure 5.1) in the most isolated and least developed area of the country, on the outer borders of the Department of Kedougou in the Region of Tambacounda (Nolan 1986). The Bassari count a population of approximately 11,000, only half of whom reside in Senegal, making them one of the smallest minority ethnic groups in the country. Bassari country is also home to members of other ethnic groups, namely the: Coniagui, Badyaranke, Bedik and Boin groups. More recently members of the Fulani or Peul groups and a few Mandinkas have also come to live among the Bassari. The Bassari live in widely dispersed villages which range in size from approximately 100 inhabitants to as many as 600.

Bassari country or as the Bassari themselves call it, *lian*, is very remote, difficult to get to and once there extremely arduous to get around. By road to the national capital is approximately 700 kilometers and to the regional capital approximately 300. The number of kilometers, however, does not adequately reflect the time demands one must count for traveling to these destinations. For example, the first 80 kilometers of "road" leading in and out of Bassari country is rough and barely passable at best and entirely flooded out at

Figure 5.1. Senegal



worst. For at least three months, and sometimes five months of every year, during the rainy season, it is virtually impossible to travel in, out, or around the Bassari area. These distance and transportation difficulties remain one of the greatest impediments to the economic development of the area.

### Bassari culture

The Bassari are not only geographically isolated they are also culturally quite distinct from Senegal's dominant ethnic groups such as the Wolof, Serer and Peul. Whereas most populations in Senegal are characterized as patrilineal and organized into endogamous ranked castes, the Bassari are matrilineal and organized into tightly structured age-grade systems (Nolan 1986). Furthermore, whereby most of Senegal (85%) is Muslim and practice extensive cash-cropping, the Bassari depend almost exclusively on local agriculture for their food needs and practice either their indigenous religion or Christianity. These factors, geographic remoteness and cultural distinctness, contribute to the perpetual marginalization of the Bassari people, despite their increasing contact with other Senegalese ethnic groups and a slowly growing government infrastructure in their area.

### Recent history of the Bassari

Not much is known about the Bassari as a people prior to mid 1800. However, toward the end of the 1800's oral histories and detailed scholarly accounts have described the bloody Fulani jihads or Islamic holy wars that swept through Bassari country and decimated, according to some estimates, as much as 75% of the Bassari population (Gessain 1976 in Nolan 1986). Thereafter, beginning around 1925 until the 1950's, the

French conducted massive forced labor recruitments of strong Bassari men to work in sisal plantations far to the north of Bassari villages. During the mid to late 1940's the French army involuntarily recruited able bodied Bassari men to help fight France's battles overseas. At the same time, the colonial government of Senegal began recruiting men from the Bassari area (as well as from neighboring countries) to work for sharecropper wages as wet season cultivators in Senegal's peanut basin.

While the French colonizers were the creators of these programs that took Bassari men involuntarily from their homes, the Muslim Senegalese were charged with implementing and enforcing them. Muslim Senegalese were the recruiters, overseers and bosses of the Bassari during the years of colonialism and they were known to exploit their conscripts on occasion (Nolan 1986). In fact, the known Bassari history of contact with Senegalese Muslims went from their near annihilation during the jihads to involuntary conscription and exploitation during the colonial period. Even in the present the Bassari feel justifiably exploited by their Muslim neighbors. Currently, Senegalese Muslims control the prices and "wages" paid for labor in the production of cotton which Bassaris have recently been co-opted into cultivating (Bidiar 1986). Secondly, they seem to have control over, and gain the benefits from, the seasonal flow of tourists that come to see the colorful Bassari rituals. Lastly it is the Muslim Senegalese who collect money from the Bassari to pay annual taxes to a government from which they receive nothing.

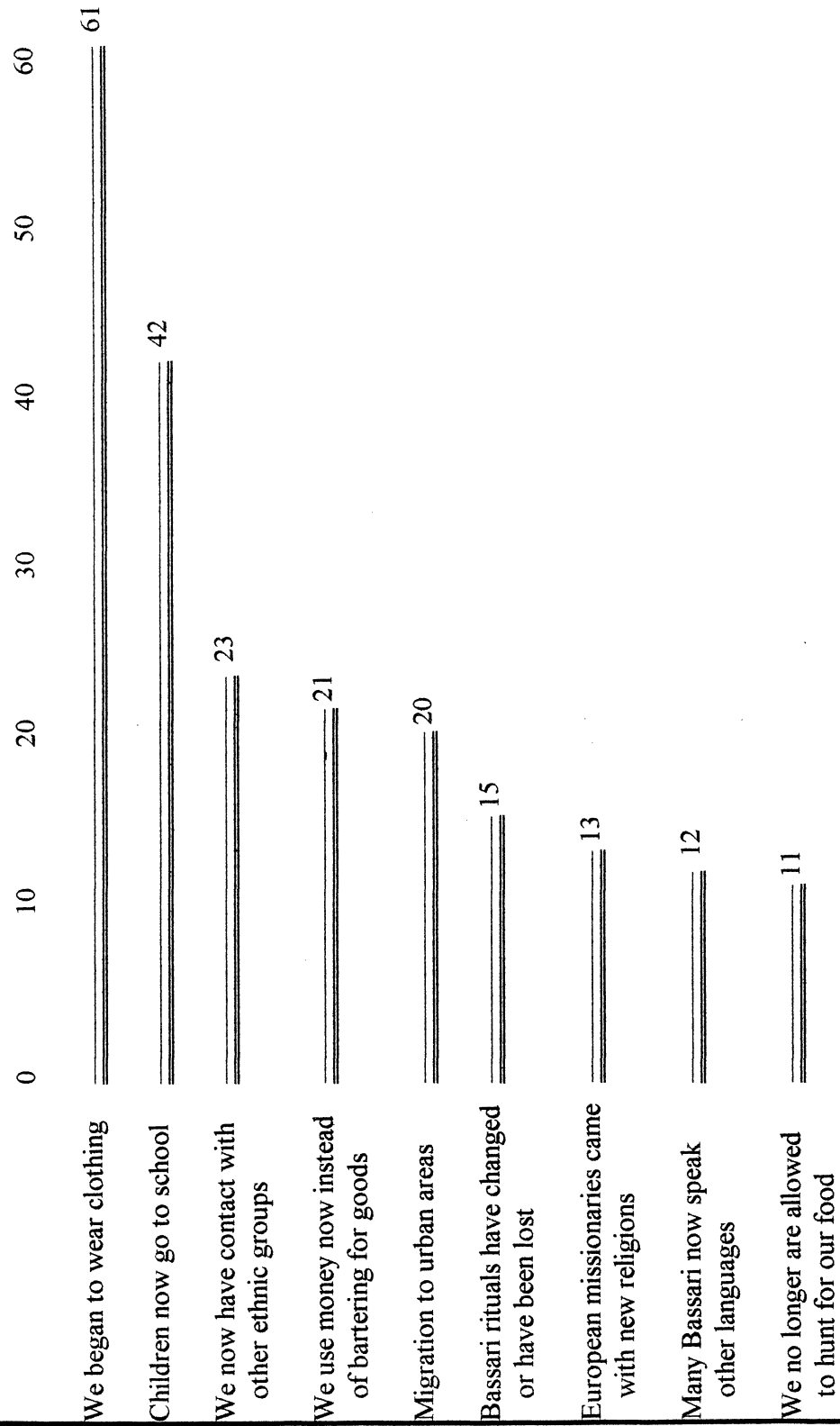
It is no wonder that the Bassari have come to fear and distrust Senegalese Muslims. Although many Muslims (mostly Peul) have come to co-inhabit much of Bassari country, Bassari hostility toward them is still prominent and reflected in Bassari language

and everyday life (Nolan 1986). In fact, most older Bassari are openly resentful of Muslims. Ironically, because the Bassari had less directly threatening contact with the French, compared to the Muslims, they have been much more accepting of French (and other European) people. For this reason, along with their long-standing distrust of Muslims, the Bassari appeared to be especially receptive to the teachings of EuroAmerican, mostly Catholic, missionaries. As a result, Bassari country, as well as all Bassari points of migration, have both Catholic and Protestant missions. As will be discussed below, these missions have become integral to current day Bassari life.

As a people the Bassari have transformed substantially over the last two decades. They have become politically interdependent with outsiders (European missionaries), they have entered into the market economy, and they have begun to voluntarily migrate out of Bassari country. Figure 5.2 illustrates the relative importance the Bassari themselves place on the various cultural, political, and economic changes that have recently affected their lives. The responses are from the structured interviews with Bassari villagers and healers, all of which began with the following open ended question: What are the greatest changes you have witnessed the Bassari experience in your lifetime? Greatest was defined as having the largest impact. The responses illustrate how very recently the Bassari people have come to associate with people from "the outside world," wear clothing, send their children to school and even alter their belief systems by incorporating new religions. Other changes cited by 10 or fewer people include: changes in subsistence foods; the use of non-Bassari healers and medicines; improvements in agricultural techniques; changes in men's appearance/customs; and a new, sometimes overwhelming concern with money.

**Figure 5.2**

**Bassari perceptions of the greatest changes that have occurred to the Bassari people in recent times**  
 (N = 74, responses = 218, average 2.9 responses per case)





### **Changes in Bassari health and healing systems**

Many of these changes have left the Bassari vulnerable to new health problems. The increased contact the Bassari now have with other ethnic groups in and around the Bassari area and from the cities has led to a growing number of new illnesses for which they have little or no protective immunities. In fact a few maladies, such as *danéwell* (a Peul word perhaps referring to a form of hepatitis B) or *calia* (a Bambara or Malinké word referring to hernias) are thought to be so new to the Bassari that they have yet to assign words to them.

In addition, the entrance of the Bassari into a money economy has contributed to changes in village and familial dynamics and power structures. These changes subsequently affect the demography of health. Those who are more able to obtain money are similarly more likely to obtain health care from indigenous healers, who now ask for money, or from the missionary nurse who is required by the government to charge a fee for her services. In other words, when bartering for health services and medicine was the norm, the elders were able to procure the necessary valued items to receive care for themselves as well as their relatives. Today mostly youth are earning money, and according to several informants they are not sharing it with their village elders. Because most Bassari have little to no money and little means of acquiring it, the requirement of a monetary fee for health care has effectively eliminated segments of the population from accessing health services.

Another recent change has adversely affected Bassari health and nutrition. Whereas in the past, large animals acquired from hunting made up an important part of the

Bassari subsistence diet, this is no longer true. Due to recent "ecopolitics" and the government's desire to protect the tourist industry, and therefore the game parks, new laws and regulations have been created which effectively ban the killing of game animals. As a result, the Bassari's dietary patterns have changed as they can no longer procure the same nutrients as in the past. This change may be an important factor related to the current epidemic increases in goiter prevalence seen throughout Bassari country. Although this relationship has not been examined and would require further study, three hypotheses, based upon previous work on the etiology of goiter (Roche and Lissitzky 1979), can be suggested:

- 1) If the soil and water and consequently the foodstuffs were poor in iodine in Bassari country, the Bassari may have previously acquired adequate iodine from eating highly mobile game animals who grazed on plants and drank water in iodine richer areas.
- 2) Changes in the quality and quantity of foods consumed may have heightened the goitrogenic effect(s) of particular food sources consumed by the Bassari.
- 3) The absorption or utilization of iodine became hampered once the Bassari had less access to animal proteins.

Current circumstances related to the transition between healing systems are also having adverse effects upon the Bassari. As the awe of magic bullets and biomedical pharmaceuticals, delivered through the agent of the missionary nurse, spreads in Bassari country, traditional healers are slowly losing their clientele, their prestige and ultimately their will to train future healers. Of the six indigenous healers I interviewed only one demonstrated concern for the plight of Bassari healing practices and was actively training someone to become a healer. Consequently, as Bassari healers become less sought after, mission medicine becomes the health system of preference.

This transition between health systems, mirrored throughout rural Africa, brings about unforeseen problems and difficulties. In the recent past every village cluster had at least one Bassari healer so that health advice and services were never very far away. Even for seemingly insignificant cuts, colds or pains, villagers would seek out the assistance of the neighborhood healer. As noted previously, villagers were able to barter for services and medicines and if the healer requested a patient to return for further treatment, it was not difficult for them to do so.

Contrarily, as the Bassari become more reliant on the mission medicine, they tend to access health services less frequently. Because there is only one mission health worker, the wait alone discourages them from visiting her clinic. The lack of roads and public transportation in the area also impede the Bassari from seeking health services from the mission. For those villagers who reside closest to the mission, an entire day's work is lost when they go to the clinic. And from the more distant villages it would take an average of three days, depending upon the season, to arrive at the mission. Thus, accounting for the return journey, from this distance one would lose, at the very least, an entire week's work. Needless to say, only the very sick make the trek and the cliché concerning the patient coming too late to be helped is sustained. I was told by several informants that it was not uncommon for young men to carry a sick person by hammock the entire distance to the mission clinic only to discover that the patient had died en route.

The medicine transition, or the entrance into "pharmaceutical pluralism" is also posing new difficulties for the Bassari. Going from a total reliance on barks, roots, leaves and prayers to an increasing reliance on foreign pharmaceuticals, prescribed by the mission

nurse, is fraught with cultural, linguistic and economic challenges. As Whyte and Van der Geest (1988) suggest:

even though people of different cultures share the basic idea that a medicine is powerful, the specific nature of that power may be conceived quite differently. The characteristics that indicate potency, the expectations about how a medicine works, notions about suitable uses of a medicine's power - all these are culturally shaped in various ways.

An understanding of certain notions, such as the following, are important and sometimes essential for the successful use of biomedical pharmaceuticals:

- the need to complete certain drug regimes, such as antibiotics, even when feeling completely better
- counter-indications
- pharmaceutical shelf life
- the concept of preventive medicine (i.e. malaria prophylactics, immunizations)
- precise dosages
- individualized prescriptions

Because indigenous Bassari healers do not administer medicines with such requisites, and because neither the mission nurse nor anyone else has transferred this information to the Bassari, abuses of pharmaceuticals are frequent and sometimes lethal. The sharing of medicines, for similar symptoms, between family members and friends is common. Regardless of the medication, once a patient feels somewhat better, they stop taking it, and it is not uncommon for the second half of antibiotic regimes to be hoarded for future use. Because the vast majority of Bassari are not yet literate, precise dosages are often misunderstood or misremembered and therefore compromised. It is also not uncommon for people experiencing illness to try several different remedies

(pharmaceutical with indigenous or even several non-prescribed pharmaceuticals) simultaneously, without knowledge of potentially harmful synergistic effects. And again, because they have not been instructed otherwise, the Bassari often take their medicine with alcohol. Lastly, as the Bassari come to replace their free and naturally available indigenous pharmacopoeia with foreign made biomedical pharmaceuticals they increase their dependence upon outsiders (missionaries) for the procurement and steady supply of foreign medicines. When the mission nurse leaves Bassari country, as she does three months out of every year, the Bassari either do without medicine during that time or return to using rapidly diminishing indigenous formulas.

### **Current epidemiological situation of Bassari Country**

Recognizing that the epidemiological description of a given group is conditioned by whom is queried or which resources consulted, I sought divergent sources of information in my pursuit to learn of the most serious health problems that currently affect the Bassari people. I also believed an investigation of this nature could reveal important information about underlying reasons for why the Bassari area has been so conspicuously neglected. For example, if gaping inconsistencies or large discrepancies were discovered among the opinions of various groups, we could surmise that governmental neglect could be due more to misinformation than to willful negligence.

I began by asking the regional director of the bureau for primary health care what he believed were the most serious health problems currently facing the Bassari. He referred me to a 1990 document (*Situation Sanitaire en 1989 de la Region de*

Tambacounda) in which epidemiological data by each department in the region were presented. From this I extracted the list of the most prevalent health problems for the department of Kedougou (see figure 5.3).

Thereafter, I interviewed the director of health education for the department of Kedougou. He too referred me to a document, although more specific to the department (Plan de Developement Sanitaire du District de Kedougou 1989 - 1993). I extracted another list from this document, also for the most prevalent health problems of the department. Thereafter, in formal, taped and subsequently transcribed, interviews with both the state nurse and the mission nurse in the district of Salemata (Bassari country) I posed the same question. Unfortunately, it was not until the last interview that I realized I had not specified what I meant by **serious** and neither did my informants ask. As a result, the data in figure 5.3 are specious and cannot be used as I had originally intended. Nonetheless, I continued on to ask the Bassari, in the structured interviews, to list their most serious health problems (figure 5.4). Although all I can do with this information is present it as it was acquired and make a few general comments, I believe the aggregated data do shed light on the health problems of the area.

It actually appears that little discrepancy exists between the various sources regarding the most "serious" health problems of the Bassari. The non Bassari health providers who were asked this question emphasized the overwhelming prevalence of malaria during the rainy season. Furthermore, they all recognized the problems of parasitosis and diarrheal diseases. The additional health problems noted at the district level were probably a product of the fact that sterility, complications of circumcision or

**Figure 5.3. Government and mission perspectives of the most serious health problems facing the Bassari**

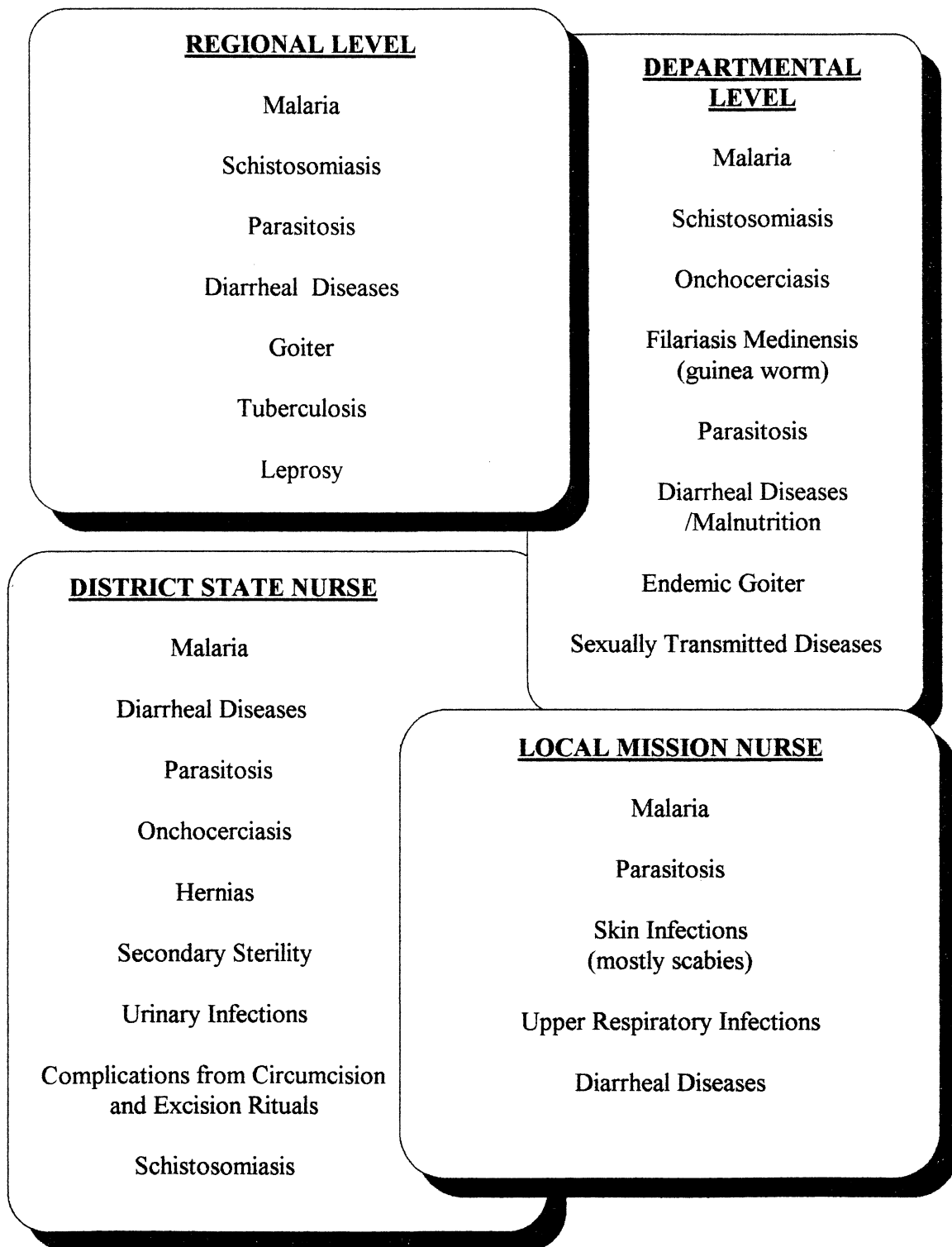
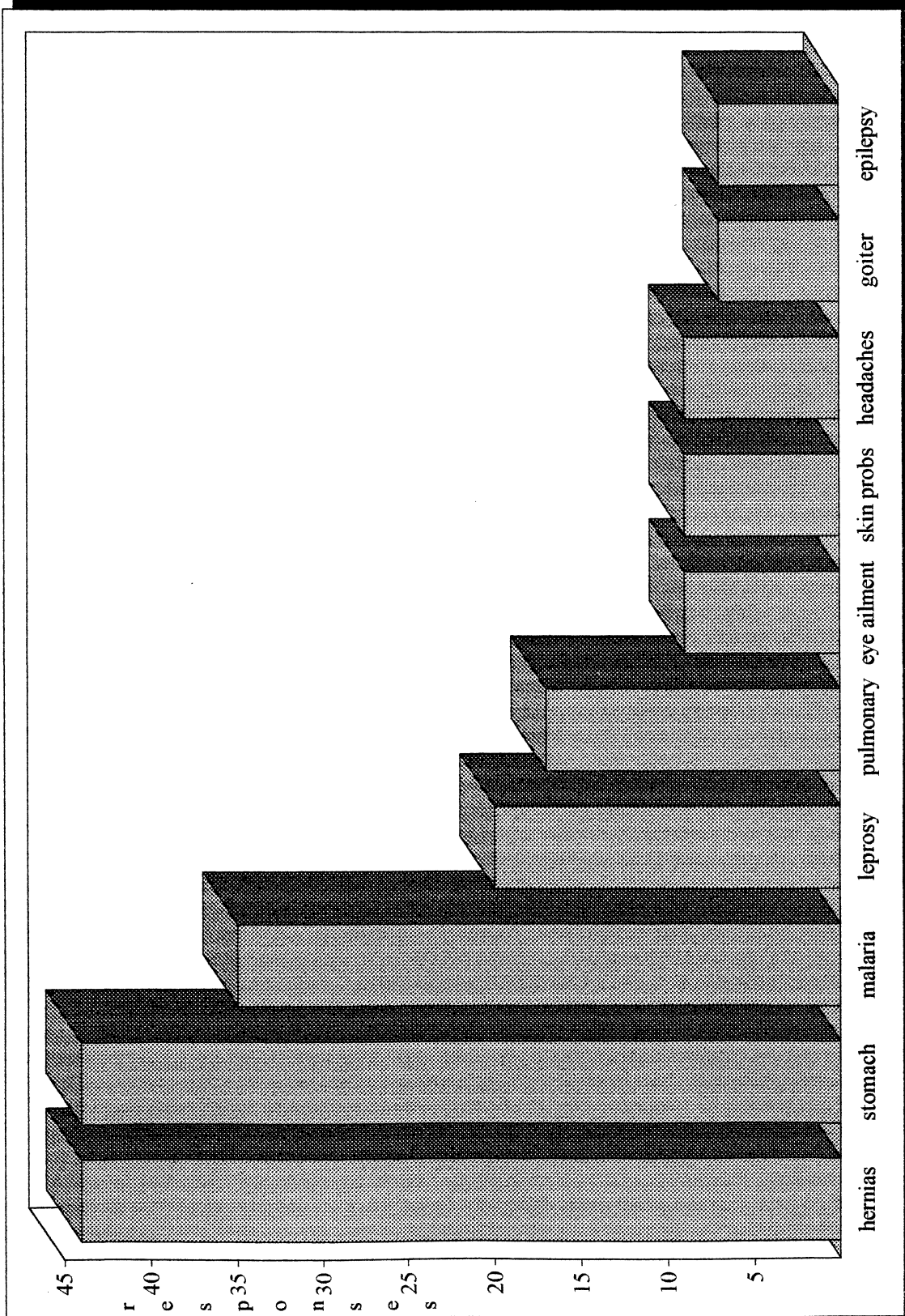


Figure 5.4. The Bassari perspective of their most serious health problems (N = 74, 201 responses).





excision rituals and skin infections are probably rarely brought to the attention of departmental or regional level health workers.

The only truly noticeable variation was between the Bassari views of their health problems and the government and mission views. The Bassari felt their number one health problem to be the excess in hernias (*calia*) experienced by their young people. I was told by several people that, "these hernias are killing our young people." I was further told that hernias were new to the Bassari and some ventured to guess their etiology: the drinking of Peul tea or the introduction of sugar into the diet (this was suggested by three different elderly men who claim to avoid the harmful substance). All six of the healers I interviewed conceded that they had no clue as to what caused the increase in hernias or to what in fact caused hernias. Apparently no Bassari specific linguistic or cultural constructions had developed yet regarding the hernia. The healers also explained that they were relatively powerless to help hernia patients other than offering them calmants for their pain. They believed that an operation was the only cure.

Another anomaly, not apparent from the data presented, concerns goiter (*é bood*). I was very surprised that neither the district nurse nor the local mission nurse mentioned goiter to be a serious problem. I was even more surprised, however, that the Bassari accorded it such (ninth on the list) low priority in their responses for the most serious health problems affecting them. My surprise derives from what I observed living among the Bassari. Almost every other women I met, or even simply saw, had goiter. Even my research assistant remarked at how prevalent goiter had become since his last visit to Bassari country four years prior. In casual conversations, when I was not conducting

structured interviews, people frequently spoke about goiter. No one understood what caused it and why it had become so great a problem so fast. Unlike hernias, I was told that the Bassari always knew goiter, but it used to be relatively rare among them. Several women pleaded with me to please help them resolve this mystery. Clearly, a further multi-disciplinary (with an epidemiologist, nutrition scientist and anthropologist) study would be warranted for this question.

### **The current state of public health among the Bassari**

As noted in chapter one, Bassari villages are virtually void of development projects and health promoting activities. Of the thirty or so Bassari villages situated in Senegal, very few have functioning primary schools, access to safe drinking water or village based case de santés. Even fewer (two or three) participate in some kind of sanitation program, income generating activity, agricultural enhancement project or health information campaign. In terms of water availability, education, and health, Bassari villages are among the least developed and most impoverished in Senegal.

With the exception of the EPI (expanded program on immunization) which was administered by the mission nurse, the Bassari have had very little contact with, and have received virtually no assistance from, government sponsored, internationally supported Health for All campaigns and primary health care activities. Whereas most districts in Senegal have been targeted for several of the following programs during the last five years

(Ministère de la Santé 1993), the Bassari area has not been approached by government health or development workers for any of them:

- 1) the training of village health workers or traditional birth attendants
- 2) the oral rehydration therapy education
- 3) malaria prevention education
- 4) nutrition surveillance and education programs
- 5) the construction of village-based primary health care centers or case de santes
- 6) the digging of new wells, the installation of water pumps and other water improvement projects
- 7) family planning and maternal and child health education campaigns

The conspicuous absence of these programs in the Bassari area is in large measure due to the distance and difficulties in traveling between the regional capital (where such programs are administered) and the Bassari area. However, as will be discussed in detail in forthcoming chapters, distance alone does not account for this marked inequity in programs and services and the striking neglect of the Bassari people.

As for community public health beyond the village level, the picture is somewhat different. A discrepancy exists between what is available to the Bassari and what is actually used by them. In reality, there are three different health posts in the Bassari area: two government *postes de sante* and the Catholic mission health clinic. One government health poste is located literally 200 meters from the Catholic mission and the mission health clinic in the arrondissement capital Salemata. The other government health post is located approximately 45 kilometers from the other two in the town of Oubadji. Yet despite the availability of these other health posts, the Bassari **only** rely on the mission nurse and go **only** to the mission clinic. The government health posts, on the other hand, are frequented by the other ethnic groups who reside in and around Bassari country. Why

the Bassari themselves do not also use the government services will be outlined below and further discussed in chapter six.

Prior to March 1992 the centers were seriously lacking in all essential medicines. One frequently cited reason for why the Bassari did not use the government health centers was this chronic lack of medicine. When a patient required a certain medicine that was not available at the *postes de santé*, the state nurse would write a prescription for a medication which he knew could not be purchased locally. Few Bassari had enough money to pay the two way ticket required to get to the departmental capital, a six hour journey away, to be able to purchase medicines with artificially high prices from privately owned pharmacies.

When I arrived in the Department of Kedougou in the beginning of 1992, the state nurses believed that the drug supply problems were about to be resolved with the implementation of the long awaited Bamako Initiative. This initiative was created in 1987 when health ministers of African nations met in Bamako, Mali to resolve the drug supply and maternal and child health problems of sub-Saharan Africa (Lancet 1988). The initiative's aim was to supply rural health posts with all the essential drugs needed for the normal functioning of a health center. The drugs were then to be sold to patients in increments, at two to three times cost price, so they could be continually restocked and health centers could become more self sufficient. Although I was not present in the Bassari area long enough to make an assessment of its efficacy, I believe, as do other researchers, that the requirement to pay for medicines will, once again, impose a barrier on the poorest segments of the population (Lancet 1988, Van der Geest 1992). In other words, however

good the intentions, this cost recovery program will probably disable the Bassari from participating and will further compromise the goals of equity in health service provision.

Both government *postes de santé* are directed by state nurses and are equipped with minimal supplies and materials purchased by the Ministry of Health or donated from UNICEF. As of May 1992 there had never been a Bassari state nurse in one of these health centers. In fact, neither of the two nurses who operated the centers, during the time when I conducted this research, were conversant in the Bassari language or had even a minimal understanding of Bassari culture. This is despite the fact that one of the nurses had lived and worked among the Bassari at the same *poste de sante* for over fifteen years. Although none of the Bassari I interviewed mentioned this lack of language ability and cultural appreciation of the nurses as a contributing factor to why they choose not to use the government health posts, some references were made to the fact that the nurses "don't care about" or "don't understand" the Bassari people.

Another reason why the Bassari chose not to use the two government health posts in their area was the inadequate referral system. As is the case for most health posts throughout Senegal, the structure of the center is built to accommodate a consultation room, a supply room, and the living quarters for the nurse and his or her (there are still very few female nurses in Senegal) family. There is little room to accommodate patients who come from far away and are too sick to make the return journey. When a patient's malady was considered beyond the capacity of the state nurse to treat, he or she was either urged to go on their own or was transported by government vehicle to the departmental capital, a difficult six hour journey away. Because there is no regular transportation to the

department capital, seriously sick people are often left at the mercy of one or two government functionaries for medical evacuation. For this transportation, when forthcoming, the patient is usually asked to pay an astronomical amount of money, often in excess of their annual income. If the patient is fortunate to arrive in the department capital, Kédougou, medical assistance and/or surgery from the one medical doctor is not guaranteed. As of 1992 this one state physician was responsible for a population of over 73,000 people. But even more problematic than the lack of personnel was the fact that the one physician, at the time of this research, had a serious drinking disorder: he was very frequently indisposed and unable to serve his emergency patients. Just prior to my arrival in the department he had been flown, on an emergency basis, to the regional hospital for incapacitation due to severe alcohol abuse. And although the health ministry chain of command was aware of his condition, he had not been relieved of medical duties.

But beyond all of the above stated problems, the most salient reason why the Bassari do not utilize the government services is the very fact that they have an alternative. This alternative is the privately operated, government regulated, Catholic mission and mission health clinic. For the Bassari it makes infinitely more sense to use the mission health clinic. Most significantly, it is cheaper than the government services. For a nominal fee (about 25 cents for adults and 12 for children) a patient is tested, diagnosed and given the necessary medicine for the malady. Additionally, the mission nurse has more equipment available to her for diagnosing illness and has the space to offer seriously sick people a place to heal or recuperate. She also seems more empathetic to the Bassari because she understands a little of the Bassari language, allows her patients to pay their

fees in kind (with grains or eggs), and often agrees to evacuate seriously ill patients, in one of the mission jeeps, free of charge. Moreover, the Bassari are more familiar with her because she visits villages regularly to administer immunizations and occasionally stock one of the few village primary care huts. The mission has also encouraged several villagers to become primary health care workers. Yet despite all of the mission's efforts and the trust the Bassari seem to have in the mission nurse and health clinic, every Bassari I interviewed emphatically explained that the mission nurse and public health infrastructure in the area were totally inadequate. Yet, in pleading for more health assistance, by way of personnel and resources, the Bassari do not recognize or perhaps pretend not to recognize the government facilities and state nurses as other possible sources of health care.

The mission has had a powerful presence in the affairs and activities of the Bassari and in many respects operates as a surrogate government to them. Due to the underlying distrust the Bassari have with Muslims, and therefore most government representatives, they have purposely maintained a distance from government personnel, organizations and activities. In fact, the only regular contact and connection the Bassari have with the government is through the annual collection of taxes. So although they do pay taxes to the state, they do not request and certainly do not receive any benefits from them. Instead the Bassari rely on the foreign run Catholic mission, with whom an interesting symbiotic relationship has developed. Because the Bassari represent the only significant population of non-Muslims in the area, the mission's very presence in the region is dependent upon their remaining non-Muslim. As other ethnic groups in Senegal have demonstrated, the more intertwined a group becomes with the government, the more likely they are to

convert to Islam. In other words, the Catholic mission in the Bassari area has a vested interest in keeping the Bassari distant from the Senegalese government. In exchange, the mission provides basic services to the Bassari, such as health, education and agriculture.

According to some urban-based, educated Bassari, this symbiotic relationship may be **in part** to blame for the underdevelopment of the Bassari villages and ultimately for the gross inequities that exist between the Bassari and the rest of Senegal. As the government concentrates greater efforts in the rural areas of Senegal and begins to respond to the demands of first and second generation educated rural elites, villages are beginning to realize some of their basic needs. Similarly, as the international health community continues to support massive Health for All and primary health care campaigns, rural dwellers are beginning to reap some of the benefits. But because the Bassari have distanced themselves from the government, they do not receive any of this rural assistance. Instead, for convincing demonstrations of conversion or adherence to Christianity, Bassari villages get mission "gifts," such as a cement lined well, a vegetable garden project, a small village based pharmacy, or a Catholic primary school. The problem is that the mission is very small, around ten full time missionaries, and has quite limited resources. So the villages that are closer to the mission or who have demonstrated their devotion to the church receive the bulk of the available resources while distant villages and those most in need go entirely unassisted. Thus, even between Bassari villages questions of justice and equity arise.



## **Bassari Health and Healing**

In the first phase of this research I interviewed public health officials from every administrative level of the Ministry of Public Health. These interviews enabled me to expose national, regional and local level rationalizations for why the Bassari had not received and were not targeted to receive government health and health promoting projects. They also helped shed light on the various ways in which public officials make decisions that result in the inequitable distribution of health resources and personnel. While most national level decision making regarding resource allocation is constrained by global forces (to be discussed in Chapter VII), the choices that Ministry level functionaries have had the autonomy to make concerning the department of Kedougou and Bassari country, have been guided largely by misinformation.

The most important misinformation with which decisions have been made concerns the quantity and quality of care currently utilized by the Bassari. One of the most frequently cited reasons for why the Bassari were not in need of governmental assistance to improve their public health was the "fact" that the religious missions in Bassari country provided excellent and adequate care to the Bassari. In fact, prior to my arrival in Bassari Country, I was given the erroneous impression that several mission nurses were spread out and working throughout the area. The adherents of this view were mostly national level public health functionaries. No one at this level could tell me first hand, however, of the Bassari situation because, of the four people I interviewed from the Ministry of Public

Health, no one had been out to Bassari country. Their collective belief concerning the adequacy of the "missions" was based, not on ignorance, but on the yearly reports filed by the Catholic mission and ministry representatives working at the regional and departmental levels. An underlying question thus emerges, why would the mission and local level ministry personnel purposefully distort the Bassari situation?

Other misinformation passed on to the national level involved the indigenous health care system of the Bassari. In defiance of Senegal's continued dependence on the "West" and on non-African health systems, the regional level health administrators spoke idealistically and in admiration of Bassari culture and indigenous healing practices, which they considered to be the best "preserved" in the nation. Four regional level health administrators informed me that the Bassari were well known in the region for their powerful healers and healing practices. I was also told by government functionaries that the Bassari are "too attached to their own ways of preventing and curing illness to need or want the highly Westernized medicine offered by the government." Health Ministry representatives further intimated that the Bassari were "traditionalists" who preferred to be left alone. Moreover, I was told, if the Bassari were truly in need of more health services they would have made formal requests to the government, as other ethnic groups frequently did.

To examine the validity of these claims, I spent six weeks in rural Bassari villages observing daily village life, illness episodes, indigenous therapeutic practices and treatment strategies. As described in the previous chapter, the religious missions had but one extraordinarily overcharged health worker between them. Although she was well

respected, most of the Bassari I spoke with believed that her services were simply insufficient. Not only did she cater to the Bassari, she also worked with all the other inhabitants of the area, serving as many as 17,000 people.

In addition, I examined the claim that the Bassari do not want or need health supporting projects or assistance from the government because of their total satisfaction and reliance on their own healers. This required extensive structured interviews to learn how the Bassari perceive their own therapeutic choices and preferences. Throughout this second phase of the research, through every interaction and interview, I scrutinized Bassari notions of need. Are the Bassari as rigidly attached to their indigenous health care as the government officials suggest and, if so, does this preclude them from seeking out alternative therapies when available? Or, are they so satisfied with the Bassari health system, as it is, that they express no need for improvements or expansion of the health infrastructure and personnel? To be able to ask these questions and make sense of the responses I needed to know how the Bassari construct illness: how it is caused, prevented and ultimately cured. If, according to the Bassari, illness is caused solely by supernatural forces (i.e. the spirits of ancestors or of animals) which can only be cured with the help of people who understand and relate to the spirit world, it would then be clear why the Bassari perceive no need for more and improved mission or state medicine. The results of the structured and in depth interviews that delve into these questions are presented in this chapter. I begin by briefly describing the therapeutic options that are currently available to the Bassari.

### Choice of therapies

Currently the Bassari have several therapeutic options from which to choose. Apart from the Catholic mission nurse, the Bassari also frequent healers, fetishists and non Bassari specialists. There are at least four kinds of Bassari healers (*a hora* - healer, *a fackene* - one who heals): 1) herbalists, 2) spirit healers, 3) those who work with herbs and practice spirit healing, and 4) herbalists who work only with women and children. In conjunction with the healers are fetishists (*a lacha*) who diagnose problems that originate from disgruntled ancestors or other discarnate beings. The fetishists teach their clients how to appease their ancestors or reconcile their differences with spirits or entities, through elaborate prayer and offerings to the inanimate objects that embody the souls of ancestors. Some fetishists also practice herbal medicine or *bejjan br batuch* (the medicine of the trees). Lastly, the Bassari recognize and utilize the healing abilities of certain non-Bassari healers and individuals from other ethnic groups who specialize in the curing of one kind of illness or injury. For example, many Bassari villagers mentioned the abilities of neighboring Malinké bone setters (*a jome*), as well as the power of particular Peul Islamic religious leaders (*marabouts*).

Most healers, fetishists and religious leaders diagnose the illnesses of their patients through divination (*o jack*), which is the act of foretelling the future or seeing, through different temporal dimensions, events of the past. Unlike diagnosis in biomedicine, divination seeks to answer questions concerning primary and secondary levels of causality, i.e., who or what sent the bug here in the first place, and why did it affect me and not the other person (Kirby 1993: 238). The means by which the Bassari perform divination and

the meanings embodied in it are unique to the Bassari. Yet they, like most African cultural groups, continue to use divination as a "trusted means of decision making and a basic source of vital knowledge" (Peek 1991:2). Through the reading of cowry shells, basket sieves, miniature mats of tiny palm fronds, or the testicles of a cock, the *a jack* or diviner comes to understand exactly who or what has caused his client to become ill. After the *a jack* names the person or thing that has caused the illness, either the patient, the diviner or a fetisher must chastise the wrong doer.

While the Bassari continue to express faith in the pre- and foretelling abilities of their diviners, the diagnostic phase of the healing process appears to be one element of the Bassari health system that is actually losing the support and the confidence of many people. Several factors may contribute to this loss of faith in Bassari diagnostics. First, the blaming and then punishing of potentially innocent family members and good friends for the illness of a loved one brings to bear many negative manifestations. The distrust, fear and animosity which can transpire due this form of blaming is especially problematic for a remote communal society where people are entirely interdependent upon one another. Secondly, the Catholic mission nurse and two mission Sisters expressed great disdain for this element of Bassari culture, and I was told actively discouraged people from partaking in the blaming of others for illness. The sisters believed that the Bassari were unable to reach their spiritual, or even material, potential because of the ubiquitous fear of being blamed for the illness or wrongdoing of others. In addition, as the Bassari become more familiar with the diagnostic technology of biomedicine, through migration, contact with hospitals, or even the minimal equipment that the mission nurse has available in Bassari

country, they are beginning to appreciate it as a palpable alternative to the negative implications of blaming. In fact, in the structured interviews I conducted with 74 individuals, 32 (43%) people mentioned the differences in diagnostic capacity between the mission health clinic and the *o jack* as a major reason why they now prefer mission medicine to Bassari medicine. In a general sense this growing disillusionment with the diagnostic process of Bassari health has become a catalyst for transition of preference from Bassari health to mission or state health care. In other words, especially for more mobile Bassari, it has become easier to blame small entities (microbes), invisible to the naked eye, for one's illness than to blame, and subsequently punish, a family member or friend. It is also easier to drink the liquid, take the pill or receive the vaccination against these entities than to publicly blame and humiliate (or be humiliated by) family and friends.

Before asking people about their personal preferences, I asked them to explain what the differences were between the mission nurse (or other mission or state healers they had known) and Bassari healers. The question was asked of 74 individuals in an open ended format such that some people gave more than one answer (table 6.1). The majority of the answers (79%) were almost entirely without bias or qualification regarding which one was better. Not surprisingly, the Bassari did not appear to categorize healers in the same way social scientists and some biomedical providers do; whereby indigenous healers respond more to the psycho-social being whereas biomedicine operates more exclusively with physiological pieces of a body. The responses to this question enabled me to understand and contextualize the health care choices and preferences of the Bassari.

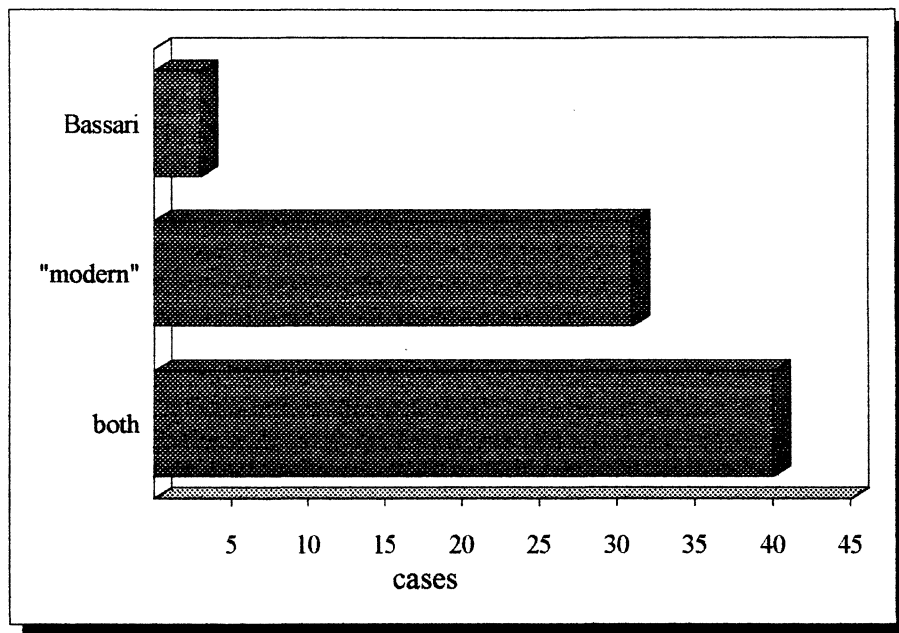
**Table 6.1 Bassari views regarding the differences between the Catholic mission healer (or other biomedical healers) and Bassari indigenous healers (N=74, 1.43 responses per case)**

WHAT ARE THE DIFFERENCES BETWEEN MISSION OR STATE NURSES AND BASSARI HEALERS?		
RESPONSES	FREQUENCY	PERCENT
The difference is in their education	23	22%
The difference is in the medicine they use	21	20%
There is no difference between them	14	13%
The difference is in the way they diagnose	14	13%
The difference is not in the healers but in the illnesses that each can treat	12	11%
Bassari healers use trial and error whereas the mission nurse knows which medicine is for which malady	12	11%
Bassari healers can't cure people internally as can the mission medicine with vaccines and operations	6	6%
Anyone who knows trees can become a Bassari healer whereas mission healers must learn beyond what their parents can teach them	4	4%
total:	106	100%

I then asked the respondents to state their preference between the mission nurse (or other "modern" healers they had encountered) and Bassari healers (figure 6.1). Because of the emphatic belief of Ministry of Health personnel at the regional level that the Bassari are traditionalists who "prefer their own medicine" I was somewhat surprised by the responses. Over half, or 54%, of the respondents told us that they had no real preference between mission healers and Bassari healers or that they "prefer them both." Most of these people later went on to explain that for some illnesses, such as those that are specifically "Bassari in origin," one must be treated by a Bassari healer. Otherwise, they noted, all other maladies can be successfully treated by the mission nurse. This

indication that one chooses which healer to use according to the illness was restated by many interviewees. Even a majority of the 42% of the sample population who said they preferred "modern" healers went on to suggest that for certain maladies Bassari medicine was the more effective.

**Figure 6.1 Bassari preferences for healers (N=74)**



To better understand these data, I developed several hypotheses concerning preference for healers as related to: gender, age, residence (rural or urban), level of education, number of migrations, length of migrations, and destination of migrations. With the single exception of residence, none of these variables were significantly related to one's preference of healers. There was no statistical difference for preference of healers between women and men ( $\chi^2 = .924$ , 1 df), between older and younger people ( $\chi^2 = 1.030$ , 1df), between people who attended school and those who did not ( $\chi^2 = 1.255$ , 1df), between people who migrated and those who never migrated out of the rural areas ( $\chi^2 = .002$  1df),

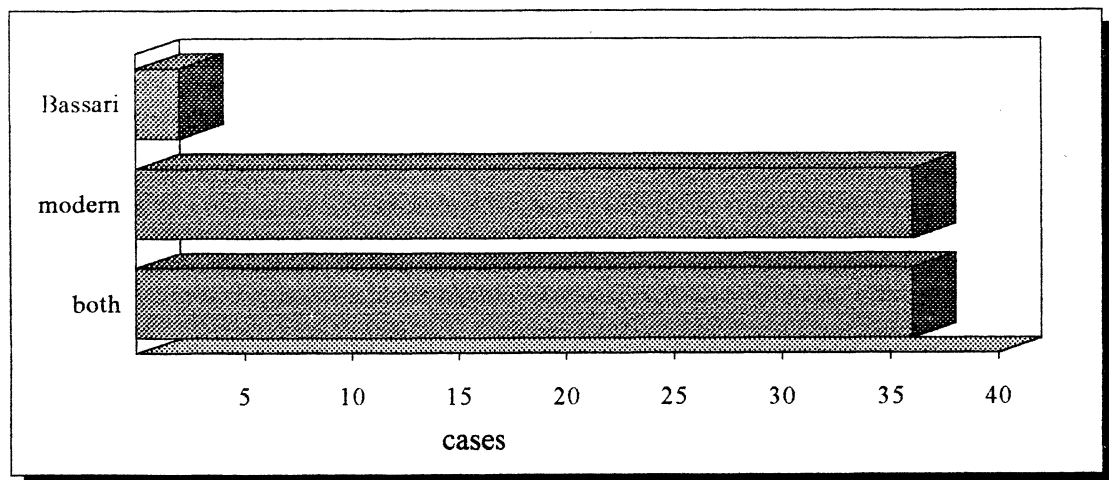


and lastly between people who migrated to the regional capital versus people who migrated to smaller less Western influenced areas ( $\chi^2 = .067$  1df). Only the actual current area of residence was significantly related to one's preference of healers. This was significant at a .05 probability with a chi square value of 5.52 with 1 degree of freedom. However, the phi coefficient revealed that only a slim negative relationship exists between one's residence and preference of healer ( $\phi = -0.273$ ). In other words urban dwellers were slightly more likely to choose "no preference" or "I prefer them both" to either the mission healer or Bassari healers. Of course this may be explained by the differences in availability of both kinds of providers between the rural and urban areas.

Again, because of the comments from representatives of the Ministry of Health regarding the unequivocal preference of the Bassari for "their own medicine," I also examined Bassari preferences for medication. Figure 6.2 illustrates the distribution between individuals who had no preference or "prefer both" kinds of medicines to those who prefer mission or "modern" medicine or Bassari medicine. To determine whether relationships exist between one's preference of medicine and demographic factors, I performed chi square analyses using the same variables as above. As predicted, a very similar pattern emerged. However, unlike Bassari preferences for healers, in which residence was the only significant relationship, education appeared to be an important factor related to Bassari preferences for medication. According to this analysis, a significant relationship exists (at .05 probability  $\chi^2 = 6.36$ , 2df) between Bassaris who attended school (even if briefly) and preference for mission or modern medicine. Also, not surprisingly, Bassaris who preferred the mission healer likewise preferred "her medicine"

to the roots, barks, and leaves of Bassari medicine. However, most of the people who stated that they preferred modern pharmaceuticals also noted that certain Bassari remedies were better and more effective against Bassari specific maladies. Of those who "preferred both" kinds of medicine, many noted that they both work well as long as they accurately correspond to the malady being treated. The most commonly cited reasons for preferring modern medicine to Bassari medicines were: 1) efficacy 2) precision or specificity of dosage; 3) familiarity; and 4) rapidity of cure.

**Figure 6.2. Bassari preferences for medicine (N=74)**



As explained previously, many Bassari individuals make decisions concerning which kind of healer or medicine they seek depending upon the illness for which they need care. In fact, many people suggested that certain illnesses are treated best by Bassari healers, while others are better cured by the healers and medicine of the mission. To determine if any consensus existed regarding which illnesses were most often presented to

whom, I asked the same 74 people, in an open ended format, to explain which illnesses they tended to take where and to whom. The responses are presented in table 6.2.

**Table 6.2. Which illnesses do Bassaris treat themselves, at home; which do they rely on Bassari healers to treat?; and which do they take to the mission or modern healers? (N=74, average of 1.42 responses per case)**

ILLNESSES TREATED AT HOME	FREQUENCY	TREATED BY BASSARI HEALER	FREQUENCY	TREATED BY MODERN HEALER/ MISSION NURSE	FREQUENCY
"small" stomach aches/diarrhea	31	sicknesses due to disregard of interdictions	36	serious "hernias"	27
fever/colds	24	serious headaches	26	everything	26
mild headaches	22	mental problems	10	serious wounds	15
small wounds	21	hepatitis or jaundice	8	pain all over body	10
colic	13	breathing difficulty	5	illnesses requiring "body opening" or surgery, i.e. goiters, hernias	10
non serious coughs	9	epilepsy	4	kidney pains (pain in side)	4
vomiting	1	to calm pain	3	eye problems	4
abscesses	1	illnesses that require a fetish	2	illnesses that don't require a fetish	3
<b>total:</b>	<b>122</b>	<b>total:</b>	<b>94</b>	<b>total:</b>	<b>99</b>

The above table clearly illustrates several points. Firstly, the Bassari utilize and rely on all three forms of health care. Secondly, as several people articulated, the Bassari strongly believe that some health problems are incurable by the mission nurse and her

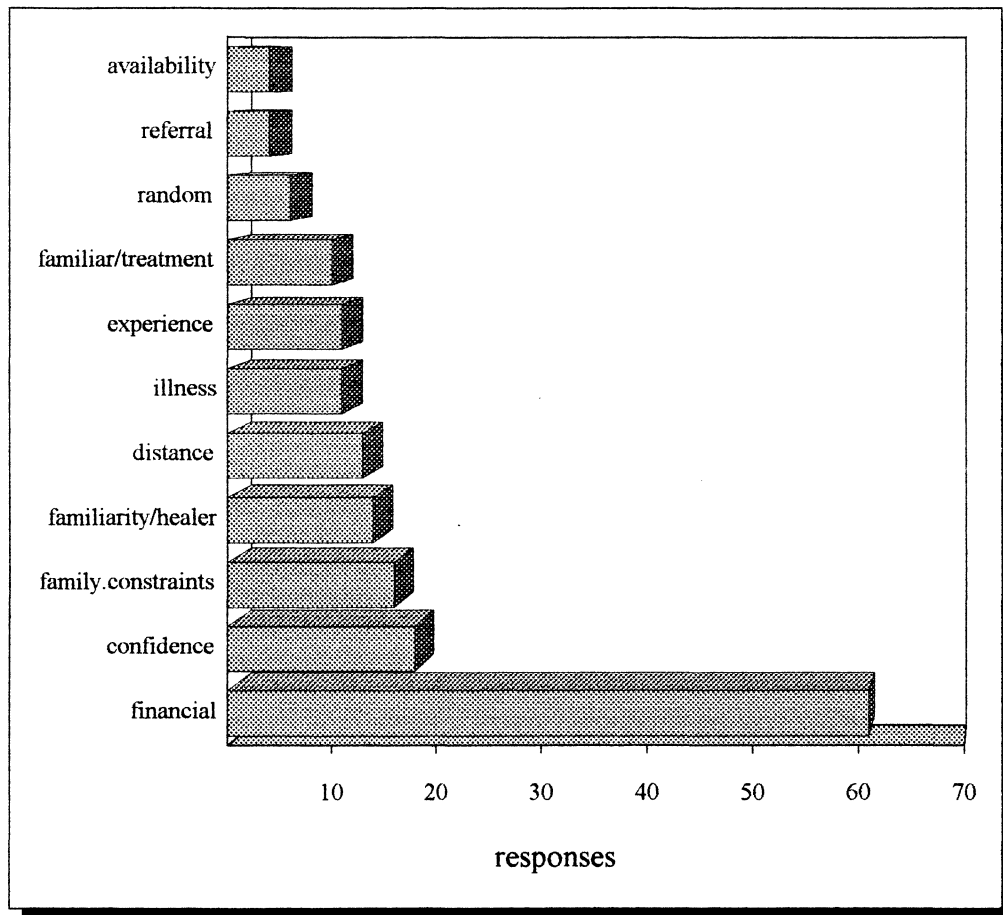
medicine while other illnesses are untreatable by indigenous Bassari healers. They, therefore, express the **need** for both systems. Further, the illnesses they believe are best treated by Bassari healers are more specific compared to those they prefer to have treated by "modern" healers. For example, health problems due to the disregard of interdictions and those requiring the assistance of fetishes are specific to Bassari culture and world view. Problems such as sterility, impotence, or mental illness are most often believed to be caused by supernatural forces and therefore require the assistance of Bassari healers, diviners, and fetishers to cure. For health problems that do not have a formally prescribed cause or a specific cultural association, such as illnesses believed to be new to the Bassari, mission or modern medicine appears to be the preferred strategy.

Through the centuries the Bassari have accumulated a collective memory for which illnesses their healers successfully treat. For these ailments, the Bassari continue to rely on their healers. Even the mission and state nurses located in Bassari country acknowledged the greater efficacy of Bassari medicine for certain health problems, such as hepatitis, specific skin problems, non serious respiratory difficulties and mental illness. In in-depth interviews with indigenous healers I inquired about specific treatment strategies for over 50 Bassari constructed health problems. And, like the mission and state nurses, most of the healers admitted that they were unable to treat every illness. They explained that for "newer" illnesses, i.e. serious goiter, hernias, and certain sexually transmitted diseases, it was imperative for their patients to seek treatment from the mission nurse. Such statements from indigenous healers help support my contention that Bassari health consumers as well as providers rely on, and feel the need for, both systems of health care.

Of course the illness suffered by an individual is not the only factor that guides a person to choose one health care system over another. In fact, when asked directly, "What factors contribute to your decision to seek help from one kind of healer or another?" most people had more than one response. As shown in table 6.4, financial consideration was the single most important factor people deliberated upon prior to making decisions regarding which health care provider to utilize. In a very distant second position, the confidence factor enters into the equation. According to these data only a few Bassari (less than 20% of the responses) suggest that they tend to seek health care from the providers in whom they have the most confidence. Virtually the same importance was placed upon family considerations: what do the parents want me to do or who do the leaders of the compound prefer me to see. Thereafter, familiarity with the healer and the distance required to travel to access a particular healer appeared to be slightly less important. In light of these data and the emphasis on the importance of illness as a major determinant to choosing a healer, I was surprised that only eleven or 15% of the responses cited illness as an important consideration. On a par with illness as a factor to consider when choosing a healer, was previous experience with healers and familiarity with the kinds of treatments prescribed by them. Still others explained that they try one healer at random and if she or he does not cure them then they go to someone else. Of course a few people pointed out that some decisions are made based purely upon who is available at the time of need. Many people noted that the Swiss mission nurse was frequently away from her post, either visiting villages, procuring medicines, evacuating patients, attending meetings in Dakar or visiting her home on holiday. Given that she was the exclusive non-indigenous health provider the

Bassari relied upon, her absences were vividly felt. Lastly, a few people based their healer choices on referral or word of mouth from trusted friends and relatives.

**Figure 6.3. What factors contribute to your choice of healer?**  
(N = 169, 2.3 responses per case)



As the figure above vividly illustrates, the price for services and for treatment very much influence Bassari health care choices. This point cannot be over emphasized given that most Bassari have very little to no money. In fact, according to health ministry documents the Bassari mean annual income is between \$20.00 and \$36.00 (Ministère de la Santé Publique 1992).

### **Current Bassari constructs of health and illness**

To learn how the Bassari define health I asked, rather too simply, "How do you define health?" in the structured interviews. Unfortunately the question was not well received, either due to the manner in which it was translated or the way in which it was asked. Several people told my Bassari research assistant and me upon completion of the interview that the question placed them on the defensive: it seemed rhetorical and patronizing. As a result, the responses we received were less than enlightening. Of the 67 people who responded to the question, 26 (39%) replied "to be well," 25 (37%) noted that health is "to be well and not sick,," while 9 (13%) suggested that health is the practice of good hygiene, and 7 (10%) responded "not sick."

More revealing about Bassari notions of health and illness were the following two questions: 1) What must one do to be in good health? and 2) What makes a person sick? These questions were asked of 74 people in an open ended format whereby an average of 2.4 responses were given for each question. The responses to these two questions are delineated in tables 6.2 and 6.3. To demonstrate that the Bassari have a wide range of beliefs regarding the protection of health and etiology of illness, I artificially created two categories of responses: indigenous beliefs and biomedical notions. This is simply to illustrate that Bassari beliefs about health and healing are not entirely asomatic or do not originate entirely in the world of spirits. In creating this artificial separation, however, I do not mean to suggest that these categories are exclusive, for several of the biomedical notions concerning hygiene, sexual relations and alcohol consumption also occur in Bassari epistemology. However, these data do serve to illustrate that a larger percentage

of current Bassari notions concerning health resemble biomedical notions of disease etiology and prevention. Unlike the views shared by several regional level government health workers, this would lead me to believe that the Bassari would respond favorably to many of the health promoting activities that the Ministry of Public Health is currently implementing around the country. For example, to the question of what must one do to be in good health, 20% of the Bassari responded "keep body, food and the environment clean" and 13% suggested to "avoid contaminated water sources or filter water." These responses, coupled with what I observed of the terrible lack of water and clean water sources in the villages, suggest to me that the Bassari would greatly benefit from water improvement and well projects. Because many Bassari are aware of the connection between clean water and health, it follows that if they had access to clean water, they would have a greater potential to be healthier. The responses to the question of what makes a person sick parallel the responses to the first question regarding health protection. And from the responses to both questions I would further suggest that the Bassari would also know how to take advantage of, and would respond well to, increases or improvements in Health Ministry personnel, basic sanitation services, malaria prevention programs (mosquito control information and bed netting) and agricultural improvement projects. In other words, given the responses to the above questions and the behavior I observed over a six week time period, I find little evidence to support the belief that the "Bassari do not want or need assistance from the Ministry of Public Health.



**Table 6.3. Bassari beliefs concerning the protection of health and the prevention of illness (N=74, average of 2.36 responses per case)**

**WHAT MUST ONE DO TO BE IN GOOD HEALTH?**

<b>INDIGENOUS BELIEFS</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Take Bassari precautions against evil spirits (i.e. ritual bathing, entrust children to forest monsters)	25	14%
Be kind to people so they don't harm you through sorcery	5	3%
Wear protective amulets	5	3%
Illness depends upon the will of gods	4	2%
Visit Bassari healers frequently	3	2%
Avoid Bassari-specific interdictions	3	2%
Avoid sleeping outside and the evil winds	3	2%
<b>subtotal:</b>	<b>48</b>	<b>27%</b>
<b>BIOMEDICAL NOTIONS</b>		
Keep body, food and the environment clean	35	20%
Avoid contaminated water sources or filter water	22	13%
Visit doctors (biomedical) and be treated for illness	22	13%
Follow Western preventive practices	19	11%
Be discriminate about sexual relations and activities	7	4%
Eat well/practice good nutrition	7	4%
Take medications	6	3%
Other responses related to biomedical notions	5	3%
Get immunized by the mission health clinic	2	1%
Drink alcohol in moderation	2	1%
<b>subtotal:</b>	<b>127</b>	<b>73%</b>
<b>total:</b>	<b>175</b>	<b>100%</b>

**Table 6.4. Causality of illness among the Bassari**  
(N=74, average of 2.45 responses per case)

**WHAT MAKES A PERSON SICK?**

<b>INDIGENOUS BELIEFS</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
<i>Abanje</i> (bad spirits that can transform into humans or animals), the <i>shabuchara</i> (spirits that move with the wind), etc.	22	12%
<i>Ojebu</i> or Bassari interdictions. By disregarding them. (i.e. women having sex with a man from the masquerade before he has washed, or the drinking of sacred wines or beers, etc.)	20	11%
Enemies, through sorcery	17	9%
Hard manual labor which causes <i>onach</i> (venom or bad blood).	8	4%
<b>subtotal:</b>	<b>67</b>	<b>36%</b>
<b>BIOMEDICAL NOTIONS</b>		
Unclean water	37	20%
Uncovered or dirty food	34	19%
Mosquito bites	17	9%
"Disorganized" sexual conduct	10	6%
Naturally occurring illness	6	3%
Animal bites	5	3%
Too much alcohol	5	3%
<b>subtotal:</b>	<b>114</b>	<b>64%</b>
<b>total:</b>	<b>181</b>	<b>100%</b>

It is worth noting that when six Bassari healers were asked, in in-depth interviews, the same two questions as above, regarding health protection and illness prevention, their responses were almost exclusively assigned to the "spirit world." It makes some sense that for someone whose very livelihood is dependent upon the faith of his patients and his ability to relate in the spirit world that he would respond in a such a manner. It also demonstrates how specious the results of this study would have been had I relied exclusively on Bassari healers to inform me of current Bassari beliefs about health and healing. Further, because three of the Health Ministry representatives in the regional capital spoke at length about how much they had learned about the Bassari health situation from Bassari healers, I strongly suspect that their conclusions regarding the Bassari not "wanting or needing" public health assistance are derived from conversations with healers, **rather than** randomly selected Bassari villagers. Although I do not wish to suggest that Bassari healers are purposefully embellishing the truth, it is important to note that healers are protecting their professional domain and livelihood when they suggest to others, as three of them did to me, that the Bassari do not want or need outside health assistance.

## **Conclusion, Policy Implications and Recommendations**

The 1980's and early 1990's have been a time of great expansion and improvement of the national health sector of Senegal. Considerable foreign health assistance was accepted by the government to bolster the infrastructure, improve health training institutes and train village level community health workers and traditional birth attendants (UNICEF 1992). In the late 1980's the government of Senegal inaugurated one of West Africa's only advanced schools of public health for the training of current and future health care providers in epidemiology, community health, and maternal and child health care. Several special campaigns, such as the nationwide EPI (immunization program), village water and agricultural improvement components, literacy campaigns, and information and communication enhancement projects, have effectively reached into every district of the nation. As a result, health ministry personnel claim that most rural villages in the country are a little better off, and significantly more well informed about health issues. Weekly and even daily radio broadcasts, aired in local languages, have been created to educate rural inhabitants about hygiene, preventive medicine, the value of the immunization program, the use of oral rehydration therapies and the potential repercussions of unprotected sexual practices. Furthermore, a much greater emphasis has been placed on community participation through committee process to essentially place the initiative and locus of control for health care improvements in the hands of the rural populations.

Yet, while the government of Senegal boasts the successes of these public health initiatives aimed at promoting the principles of primary health care and Health for All, some groups in the nation face their worst public health situation ever. The Bassari are one such group. Their indigenous health system is disintegrating, new and serious health problems for which they have little immunity and no information are becoming prevalent, and the means of compensating providers for services is becoming more difficult and even impossible. However, rather than exerting the necessary effort to help the Bassari overcome these tough barriers and this difficult time period in the spirit of Health for All, the Ministry of Health has virtually ignored them. In other words, in the case of the Bassari, the goals of "putting the needs of the poor first" and responding to the "most common health problems in communities of greatest need" outlined in the Health for All proclamation have been in large measure neglected. As Zaidi (1988) concludes, "primary health care may indeed be 'revolutionary' in its approach--at least on paper--but too many vested interests will prevent it from being truly revolutionary in practice."

Several years ago the Bassari situation would not have been an issue because the vast majority of rural populations had not received government health promoting assistance. Back then, the remoteness of the Bassari or the barrier of distance may have been reason enough why the Bassari were not adequately provided for by the health and rural development sectors. It is an important issue today, however, because the government is investing for the future by guaranteeing that all rural inhabitants have access to some branch of the health care system. If the Bassari are systematically left out of this growth in infrastructure and development process, they may experience the repercussions

for many years to come.

Therefore, so the neglect of an entire ethnic group in a remote area of the country does not remain undetected, it is important to understand why the Bassari are not receiving the government assistance that the rest of the country is and what can be done to change the situation. As this thesis has sought to demonstrate, the reasons for this health care inequity are many and complex. The causes cannot be described exclusively in terms of micro or macro level processes, nor can they be attributed to singular ideologies or political systems. Rather, the causes form a multi-directional dynamic, stemming from the government, the missionaries, the global economic system and the Bassari themselves. Each party is informed by and informs the others. And while it would be difficult to demonstrate the primacy of one cause of inequity over another cause, it is important to point to the patterns which arise. In this case, it appears, in the complex web of interrelated causes, that macro-structural factors are more outstanding than individual behaviors and cultural practices. In other words, the inequity of health care between the Bassari people and the rest of the population is more due to regional and national level systemic forces than to specific cultural patterns or behaviors of the Bassari. Yet, after careful analysis and consideration, I also believe that while the causes of this health care inequity were indeed preventable and avoidable, they were not premeditated or intentional. The following **interrelated** categories of causes for the inequitable health care situation facing the Bassari were elicited from the data and are presented below: 1) material constraints; 2) historical considerations; 3) political factors; 4) economic variables; and 5) sociocultural factors.

### material constraints

Although it is by no means the singular cause for why the Bassari have not received health care and health promoting resources and services, the geographical situation of Bassari country is certainly a large impediment. The lack of roads, public vehicles, and transportation essentially eliminate the Bassari from many government programs. The Region of Tambacounda is the largest and least populated region in the country. For regional based health officials to effectively do their work, they would require all terrain vehicles and generous allotments of gas and other travel related expenses. Unfortunately, in times of serious budgetary constraints, travel allotments are usually a most dispensable expenditure and thus health officials very rarely have the capacity to travel very far from their regional capital. As a result, community needs assessments are not done, resources are not delivered and services are not provided to distant areas. In other words, the less exposure public health officials have to an area's problems, the less cognizant they will be of them and the less likely they will initiate programs to ameliorate them.

In the case of the Bassari, even the departmental level is a long arduous six hour drive away. So, not only do the regional level health workers rarely make it out to Bassari country, neither do departmental level officials charged with overseeing the activities of the rural based state nurses. In fact, while I was in the area conducting this research in 1992, the *medicine chef* of the department made his first and only visit to the Bassari area in the several years he had been the head medical officer of the department. This visit lasted only two hours.

Another example of the material constraints that restrain the Bassari from receiving equitable health services is the sheer inability to pay for them. When available, the Bassari seek health services from the mission nurse because she is cheaper than going to a government health post. But, when she is not available they usually rely entirely upon their own healers who are diminishing both in quantity as well as quality. Even the monetary compensation Bassari healers are beginning to request for their services is often beyond the means of most Bassari rural farmers.

Another material constraint prohibits the Bassari from receiving the same health education as the rest of the country. Very few Bassaris can afford to buy or to run batteries for a radio, so that what is common knowledge among most Senegalese villagers around the country is entirely unknown to rural based Bassari. For example, few villagers knew that the mosquito transmitted malaria, or had ever heard of oral rehydration therapy or AIDS. Yet, I must add, even if a Bassari could afford a radio, it would have to be a short wave radio as no Senegalese radio stations actually make it out to Bassari country. Furthermore, unless they also understood one of the other languages of the country, the rural Bassari would not learn about health because no radio was broadcast in Bassari.

#### sociocultural factors

The Bassari are proud of their culture and of being distinct from the rest of Senegal. They are also very protective of their divergent rituals and their right to use and drink alcohol. One elderly Bassari explained to me while discussing the many differences between the Bassari and their neighboring Muslim Peuls, "Bassaris came to life in a



calabash of millet beer." The central focus of alcohol in Bassari rituals is, in fact, indisputable and many believe one of the major reasons for their interminable resistance against non alcohol drinking Muslims. Some Bassari fear that if they were to convert to Islam, their rituals would be lost and their culture would disappear. Yet, however independent and proud this resistance has enabled the Bassari to be, it has come with a price, explained further below.

#### historical factors

As noted previously, the Bassari have long been oppressed by their Muslim neighbors. As a result, they have developed an enormous distrust, even disdain, for other non-Bassari Senegalese. This distrust has essentially isolated them from their own government and led them to build alliances with Euro-American missionaries. Such a strategy was probably justified in the past as the missionaries provided resources and services (clothing, mission schools, wells, health services and medicines) that the government was not in a position to provide. However, more recently as the government expands its reach to all rural areas of the country, with water and agricultural improvement projects, schools and better health infrastructure, the Bassari area has been systematically neglected.

The local state nurse and a few urban based Bassari migrants believe that the systematic neglect of the Bassari area is due to what they described as the unhealthy symbiotic relationship that developed between the missionaries and the Bassari. The Bassari migrants, in particular, believed that the missions were standing in the way between the Bassari and their future development and better health care. They noted that

the missionaries need the Bassari in order to maintain a presence in the area. Therefore, according to several migrants, the missionaries indirectly, and perhaps unintentionally, dissuade the Bassari from organizing themselves or affiliating with the Senegalese government. For example, the missionaries limit the extent of education taught in mission schools so that Bassari children grow up capable of reading and perhaps teaching the bible, but not schooled enough to apply for government jobs. Presumably, the missionaries feared that if too many Bassari moved away to work for the government, the Bassari would no longer need the mission or worse choose to become Muslim. According to some migrants, the missionaries actually tell the villages that if they don't accept Christianity then they won't receive services, such as wells, health services and agricultural supplies. They do this with impunity because they represent the only form of external "government" or authority that the rural-based Bassari have ever come to trust. At the same time, the missionaries are few and have limited resources, so that most Bassari villages do not benefit from their services anyway. Further, their health services are rudimentary and, apart from the immunization program, are almost entirely curative in nature. In fact, in general, medical missions in Africa have been criticized for "failing to develop more progressive and comprehensive health care programs in line with standards that did not exist during their developmental period" (Good 1991). Ultimately, the Bassari's exclusive affiliation with the missionaries is at the expense of their receiving more comprehensive government resources and services.

economic factors

In a country with very scarce natural resources, tourism has become one of Senegal's most lucrative industries. However, with the rapidly encroaching Sahara desert and the under-management of the few minimally inhabited game reserves, the tourist industry has had to rely on beaches, and on "native peoples," to sell the country to would be European and American tourists. But since most of the country is now Muslim, the rich masquerades and colorful indigenous African rituals that attract tourists are rapidly diminishing. The Bassari are one of a very few groups in the entire country who still use masks, practice classic "African type" dances and celebrate frequent and colorful initiation rites and other rituals. They have, thus, become very important to the tourist industry.

In fact, national and regional level health representatives speculated in formal interviews that perhaps one reason why the Bassari area was so underdeveloped was due to the Senegalese government's need to keep the Bassari "savage." The implication was that if roads, water improvement projects, schools and better health facilities were created in the Bassari area, either the Bassari would change (i.e. lose their colorful culture) or the tourists would somehow be disappointed. I was told later by travel organizers and agents that the Bassari were among the last of the "real Africans" and were therefore an important tourist draw for Senegal. I also noted that many of the current Senegalese travel posters were of Bassari people and that the colorful Bassari rituals were displayed prominently on postcards and on the cover of travel books. At the airport in Dakar, the restaurant is actually called *Les Bassaris* and images of secret Bassari rituals were displayed everywhere, on huge wall size photographs and in stuffed models of Bassari

forest monsters. For an ethnic group that makes up less than one tenth of one percent of the population of the country, the Bassari image was clearly targeted to appeal to tourists. Most Senegalese know very little, if anything at all, about the Bassari as a people and find such images curious.

The government and the owners of the tourist firms were not the only ones profiting from this form of exploitation of the Bassari. When rugged and daring tourists actually did make it all the way out to the Bassari area, a very few village leaders reaped the benefits from their visits. For example, in the largest of the Bassari villages, the nominal village chief and a few of his friends require tourists to pay them large monetary fees (by Bassari standards) for the privilege of taking pictures or tape recording the music. According to several villagers, they do not share this money with their fellow villagers despite the fact that everyone contributes time and resources to the ritual festivities.

Furthermore, in recent years the Bassari have become targeted as a potentially important labor pool for the production of cotton. Regional and national level private and state owned industries have attempted to make arrangements with Bassari individuals and village groups. According to several informants, however, these arrangements have never benefited the Bassari and have often contributed to the economic hardships already faced by Bassari farmers.

#### political factors

The severe budgetary constraints facing the government of Senegal force ministries to make difficult decisions regarding the distribution of personnel and the dissemination of resources. The Ministry of Public Health has most often chosen to focus its resources in

areas where public officials have family or in villages that appear to have high degree of potential for success. This is because successful health interventions and projects located in areas not too far from capital cities are used as show cases to attract more funding from representatives of international health and development agencies (i.e. the Sine Saloum Rural Health Care Project, U.S. AID 1980). Consequently, these villages are the recipients of much government assistance. The Bassari, on the other hand, who have no advocates in the Ministries, are unlikely to benefit from any political favoritism. Furthermore, they live much too far away to become a show case area. It is too difficult to get to them, and ultimately if the government ever was interested in improving the health conditions of the area, it would have to start from zero. It would have to begin with very costly water and agriculture improvement projects, which it is unlikely to do any time in the near future..

Another germane political factor leading to sustained health care inequity is the absolute lack of political representation of the Bassari. In a culture where nepotism and political favoritism are the norm (Gellar 1983), it can be particularly difficult not to have "one's own" in positions of power. Three factors contribute to their lack of representation: 1) there has been little interest on the part of the Bassari to get involved in government; 2) very few Bassari are educated beyond primary school, thus there are very few Bassari who would actually be qualified enough to run for office or work in government; and 3) even if one or two Bassari individuals were to make it into politics or somehow become influential, chances are they would not actively work toward the betterment of all the Bassari.

The last point leads to another political factor which encourages health care inequity among the Bassari. Unlike other minority ethnic groups in Senegal, namely the Jola and the Soninké, the Bassari are not organized and do not demonstrate a common solidarity. Due to myriad factors, not the least of which is an undercurrent of "divide and conquer" strategizing on the part of the missionaries, Bassari villages and even families are more competitive with one another than mutually supportive. As a result, they have not made group requests for development assistance to either the government of Senegal or donor agencies. In sum, they have not effectively united together to exert pressure on agencies or even individuals (i.e. the *medicine chef* of their department) who are in positions to assist them.

Lastly, related to their lack of political representation, is the unfortunate misinformation about the Bassari health situation and misrepresentation of the Bassari as a people. As noted previously, the public health situation of the Bassari is understood quite differently by the divergent groups of individuals who are theoretically responsible for the health of the Bassari and surrounding areas. By interviewing representatives from every administrative level of the Ministry of Health of Senegal, I was able to discern where discrepancies of opinion exist and how they ultimately impinge upon the delivery of health care and health promoting services to the Bassari area. The most profound discrepancies were found between the Bassari themselves and the public health officials. Whereas 98.6% of the Bassari I interviewed believed that the health situation in their area was inadequate, the majority of health officials believed that the Bassari were adequately provided for by the missionaries.

Some officials at the national level admitted that they were not even certain whether there were, in fact, missions in the Bassari area. However, they went on to say that because the Bassari are not Muslim, they assumed missions were in their area and that these missions provided adequately for the Bassari. As explained in chapter five, in reality, there were two missions on the Senegal side of Bassari country. However, only one had a medical program that consisted of one nurse, stores of donated western medicines, and a landrover. While the nurse was seemingly inexhaustible, her services were by no means adequate.

The inadequacy of the mission health services would not be as grave a problem if the Bassari traditional health system was still intact. However, I learned from the mission nurse, the Bassari and recent ethnographic studies that the traditional Bassari health system was waning. I was told that all of the most prominent Bassari healers of this century had died and that, of the healers still practicing, most were actually charlatans out to make a profit. In addition, contrary to the beliefs of national, regional, and departmental health officials, most Bassaris preferred to use the health care provided by the mission nurse.

The inadequacy of the mission health services would likewise not be so great a problem if the Bassari utilized the two government sponsored health posts in Bassari country. They do not for several reasons. For example, one of the health posts was entirely empty of personnel and medicine until recently and is still void of equipment. The other, although somewhat equipped, is run by a male, Senegalese Muslim nurse who was not trusted by the Bassari. Neither of the two state nurses spoke Bassari or were

particularly accepting of Bassari cultural ways. Furthermore, the nurses in the government health posts were required to charge fees to patients. This fee by Bassari standards was far too expensive, and unlike operations at the mission, did not even cover medicine, which the health posts rarely had available anyway. On all counts, when compared to the mission, it appeared to my informants that the state nurses of the government health posts were trying to "rip off" the Bassari.

The Bassaris were believed to have adequate health services for other reasons. Members of three levels of the administration believed that because the Bassari had not filed formal requests to the health ministry asking for better services, as other groups do regularly, they must not be in need of other services. Of the 91 Bassari with whom I spoke not one had heard of such a procedure. While several urban-based Bassari knew that part of their difficulties stemmed from the fact that they had no political representation, none of them knew of how to request something, such as improved infrastructure or more health care, from the government.

At two administrative levels of the Ministry of Health, officials suggested that the Bassari might not need health care services because they are very powerful sorcerers and are able to ward off illnesses. While several older Bassari believed that this may have been true in the past when very little contact existed between the Bassari people and other ethnic groups, they explained that their power and sorcery was not powerful against the influx of new diseases they are currently experiencing. They emphatically believed that they needed more health services and medicines to ward off the non-Bassari maladies because their power, their healers and their medicines were ineffective against them.



The last reason offered to explain why the Bassari were not in need of further health services in their area concerned international tourists. Representatives from the regional and departmental level of the Ministry of Health believed that international tourists, who visit Bassari country during initiation rites every year, bring enough modern medicines in as gifts to provide for the Bassari. Again, this is simply not so. First, not very many tourists (approximately 100 to 300) actually make it out to the Bassari area in a given year and of those who do few actually bring in medicines. Secondly, the medicines are typically given to the village chief of the same village every year and are not shared with people from other villages. Lastly, because the medicines were not used properly and often caused people to have serious reactions, most of it is now given to the mission nurse. She complained that most of the donated medicine was either expired or inappropriate for use.

Interestingly, the health officials who provided reasons for why the Bassari health services were adequate also went on (toward the end of the interview in each case) to explain why the Bassari health services were inadequate. Representatives of three levels believed that Bassari culture was to blame for why the Bassari don't have adequate health services. To explain this, they used the same words they had used to explain why the Bassari did have adequate health care. Because the Bassari prefer their traditional medicine, and are powerful against illnesses, the government has not provided many services to them -- as they would not be used. While several Bassari did suggest that some Bassari illnesses (mostly mental problems and severe headaches) could only be

treated by Bassari healers, most every other health problem was brought directly to the mission nurse.

Politically, the Bassari are represented, and represent themselves, in diverse and conflicting ways. It has been the premise of this thesis that these conflictual representations act together as a powerful constraint to the Bassari's attainment of equitable health services. As non-Muslims or Catholics, they are believed to be adequately provided for in terms of health services provided by missionaries. As "real" Africans, who are considered closer to the earth and their ancestors, they are idealized for their powerful sorcery which gives them the ability to ward off illness and therefore not need other kinds of health care services. They are represented as "natural" and capable of curing all of their own health problems with the roots, barks and leaves of the traditional herbalist, which again suggest that they have little need for other health services.

At the same time, the Bassari are, in their current form (underdeveloped, poor and suffering from seasonal malnutrition and preventable diseases) clearly important for the tourist industry. They are used as a national model, displayed as natural and "real" Africans for Senegal to attract badly needed currency from wealthy European tourists. Bassari individuals are even in photographs in the pamphlets which advertise the animals of the national game reserve. Moreover, they are also clearly important for the missionaries to maintain their stake in that region of Senegal.

A main objective of this thesis has been to demonstrate that the causes of health care inequity can be complex, dynamic and multi-directional. They can originate from macro, micro and mid-level structures simultaneously. In order to successfully work on

behalf of groups who are not receiving equitable health care, public health workers must go beyond describing the nature of the inequities. They must examine how and ultimately why the group is denied services. I have sought to demonstrate how this can be done by examining the views of health officials (planners and providers) at every administrative level and comparing them with the views of those affected. In doing so, as this case illustrates, it is possible to gather deeper levels of insight from which more relevant options can be created for long term improvements.

### **Recommendations to Senegal's Ministry of Public Health**

Several policy implications can be gleaned from this research. The most important is the need for further multidisciplinary research. Structural based research is needed to more closely examine national and regional level impediments to providing the Bassari with basic needs development. Ministry level constraints, due to structural adjustment austerity measures and international project directives (i.e., IMF, World Bank and World Health Organization), should be closely studied. Moreover, local level research needs to concentrate on practical ways to enable the Bassari to have greater access to health care. More thorough research should be conducted on the relationship between the Bassari and the Mission concerning the provision and access to health care. Sociocultural studies should be initiated to elicit Bassari constructs of prevalent illnesses, such as hernias and endemic goiter. With an understanding of the cultural construction, etiology, physical manifestations, social manifestations and historic context of such illnesses, public health

workers would be better equipped to help the Bassari realize their own solutions to these problems.

Beyond this research agenda, a dialogue between Bassari villagers and Public Health Ministry personnel must begin. As this study has explained, a level of ignorance on the part of public health functionaries, concerning the true problems of the Bassari people, is contributing to the reification of these problems. In addition, the creation of Bassari councils or groups in both Bassari country and in the cities or points of migration could help encourage the Bassari people to work together. Any means of demonstrating to the Bassari the advantages of working in solidarity with, instead of against, one another, for the common good, will likely have long term benefits. With such groups, social workers, public health workers and others could help teach the Bassari how to make their needs known to governmental and non-governmental organizations who are in positions to lend assistance. This study also points to the importance of ethnicity in the acceptance of health services. Therefore, the Ministry of Public Health should actively recruit Bassari individuals for nurse and other health training. And, lastly, the Ministry of Tourism should work with the Bassari to help improve the tourist situation in Bassari country.

# **Appendix**

## **INTERVIEW SCHEDULE BASSARI HEALTH CONSUMERS**

1. Identification number
2. Last name, first name
3. What is your village of residence
4. What is your village of origin
5. Sex
6. Age grade
7. Approximate age
8. Migration history  
(other places lived for over six months)
9. To where have you migrated?
10. For how long did you migrate to these places?
11. Do you have children? How many?
12. Did you ever go to school? For how many years?
13. What religion are you?
14. What are your sources of income?
15. What are the greatest changes that have impacted the Bassari people in your lifetime?
16. How do you define health?
17. What are the most serious health problems experienced by the Bassaris?
18. What must one do to be in good health?
19. What are the differences between Bassari healers and mission or state healers?

20. Which do you, personally, prefer?
21. Why?
22. What are the differences between Bassari medicines and modern medicines?
23. Which do you prefer?
24. Why?
25. Can you please tell me what makes a person sick?
26. Which illnesses do you treat at home?
27. Which illnesses do you have treated by Bassari healers?
28. Which illnesses do you have treated by the modern healers?
29. What factors contribute to this choice you make?
30. When someone in the family gets sick , who makes the decision on where they should go for health care?
31. Has there been a sick person in your immediate family recently?
32. What kind of sickness?
33. Who was consulted for the treatment?
34. Are you satisfied with the health situation in this sector?
35. Can you please discuss the price differential which exists between the Bassari healers, the state nurses and the mission nurse.
36. How, or from whom, do you learn about health issues?

IN-DEPTH INTERVIEW  
STATE NURSE OF SALEMATA

1. What are the most serious health problems in Bassari country?
2. After having now participated in the Bamako initiative for one month, are you optimistic or pessimistic for the future of the project?
3. In your opinion why don't the Bassaris utilize your services?
4. In your opinion if the mission nurse and the Catholic Mission were not here what would be the condition of health of the Bassaris?
5. If you were the director of a development agency and it was up to you to plan a program for the amelioration of health in this zone, what would you do?
6. Theoretically, what are your responsibilities as chef de poste--and in reality what are you able to accomplish?
7. What are the constraints you face in doing your work?
8. Have you noticed changes in the overall health of the population since you arrived here in Salemata? If yes, what are those changes? If no, what might be the reasons?
9. Could you please tell me about the various health related projects that are currently underway in the arrondissement. What is your involvement with each project and what are your impressions of them?
10. In your opinion what motivates villagers to utilize one health service over another? For example, what factors contribute to their decision to go to indigenous healers rather than modern healers?
11. Realistically, what is needed to improve the health of the population of this arrondissement?
12. Do you use consultation files for your patients?
13. Could you please explain to me the differences in price between the modern healers such as yourself and the traditional healers?

**COMPREHENSIVE KEY INFORMANT INTERVIEW SCHEDULE  
BASSARI HEALERS**

1. Name
2. Age
3. What are some of the greatest changes you have witnessed the Bassari experience in your lifetime?
4. What are the most serious health problems currently facing the Bassari?
5. What makes a person sick?
6. How did you learn how to heal people?
7. How long have you been practicing?
8. What do you treat?
9. What methods do you use for treatment? (the trees, fetishes, washings, dance, or other)
10. How do you diagnose illness?
11. Who are your patients? Where do they come from?  
  
Has your clientele changed over the years? Why?
12. Have you remarked any changes in the kinds of health problems that are now most common?
13. Do you have an explanation for this?
14. What must people (Bassarists) do to be healthy?
15. What are the things that can make a person sick?
16. When you do not succeed at completely healing a patient, do you refer them to another Bassari healer, the mission nurse, the state nurse, or someone else?
17. Do any of these other healers ever refer their patients to you?
18. Are there illness which attack only Bassarists? Explain.



19. Can these Bassari specific illnesses be treated by "modern" healers?
20. What is the difference between what you do and what the mission nurse does?
21. What are the various methods Bassari healers use to cure their patients?
22. Do you practice divination? Can you tell me how that may relate to illness.
23. Do Bassaris have interdictions? What are they and have they changed through the years?
24. Can you speak a little about the significance of religion with regards to health and your healing practices.
25. Can you speak a little about the significance of animals with regards to health and your healing practices.
26. Can you speak a little about the significance of mountains with regards to health and your healing practices.
27. Can you speak a little about the significance of water with regards to health and your healing practices.
28. Can you speak a little about the significance of stones with regards to health and your healing practices.
29. Can you speak a little about the significance of trees with regards to health and your healing practices.
30. Can you speak a little about the significance of relatives with regards to health and your healing practices.
31. Can you speak a little about the significance of money with regards to health and your healing practices.
32. Can you speak a little about the significance of friendship with regards to health and your healing practices.
33. Can you speak a little about the significance of food with regards to health and your healing practices.
34. Can you speak a little about the significance of spirits/ghosts with regards to health and your healing practices.

35. Can you speak a little about the significance of agriculture with regards to health and your healing practices.
36. Can you speak a little about the significance of monsters with regards to health and your healing practices.
37. Can you speak a little about the significance of dreams/nightmares with regards to health and your healing practices.
38. Can you speak a little about the significance of smoke with regards to health and your healing practices.
39. Can you speak a little about the significance of caves with regards to health and your healing practices.
40. Can you speak a little about the significance of alcohol with regards to health and your healing practices.
41. Can you speak a little about the significance of language with regards to health and your healing practices.
42. Can you speak a little about the significance of dance with regards to health and your healing practices.
43. Can you speak a little about the significance of school with regards to health and your healing practices.
44. Can you speak a little about the significance of the afterlife with regards to health and your healing practices.
45. Can you please tell us about the fees you charge your patients? How do you determine exactly who should pay what? How do your patients pay?
46. Are there any illnesses which are incurable?
47. Does it seem to you that there are more, less or the same number of illness now as in the past (or in your youth)?
48. Are there more, fewer, or the same number of traditional Bassari healers now as in the past?
49. Are you currently training someone to follow in your footsteps?
50. Does it seem to you that there are more, fewer or the same amount of plants and trees available to you now as in the past?

51. Do you believe that there will always be Bassari traditional healers?
52. What are the difference between your remedies and those used by the modern healers?
53. What is the significance of the chameleon?
54. What are the origins of the Bassari?
55. What are the origins of the world? Where do people come from?
56. Where do Bassaris come from?
57. What happens to you after you die?
58. Who are the more powerful/effective healers, men or women?
59. Do your patients usually comply with your instructions? Why? Why not?
60. Is it dangerous to circulate at night? Why?
61. Who has the capacity to cure?
62. Can healers from other ethnic groups cure Bassaris?
63. How do you envision the future of the Bassaris? And their health?

INTERVIEW SCHEDULE  
MISSION NURSE

1. How long have you and the mission been here?
2. What are your responsibilities?
3. Whom do you serve?
4. What are the most serious (understood as most frequent) health problems in this sector?
5. Is there such a thing as a Bassari-specific malady? If yes, explain.
6. What do you think of the indigenous healers?
7. Do you coordinate or collaborate with indigenous healers?
8. In your experience, do people take indigenous and modern medicines concurrently?
9. In your opinion, do most people go to the indigenous healers first or do they come to you first?
10. What do you know about Bassari healers and their methods of diagnosing?
11. Could you please explain to me the medicine situation here at the mission, how you procure it and from whom?
12. Do the Bassari have other means of acquiring modern pharmaceuticals? Explain.
13. In your opinion has the health situation of the Bassari improved since your arrival here ten years ago? Why not?
14. Do you coordinate efforts with the government nurse at the health post?
15. Do the Bassari have particular cultural practices which impede you from doing your work? Could you please explain.
16. What is your relationship with Senegal's Ministry of Public Health and Social Action?
17. In your opinion, what factors contribute to a person's decision of which health provider (indigenous, mission, state) to seek health care from?

18. How much do you charge for health care services? For medicines? For medical evacuations?
19. What do you think of the Bamako initiative?
20. In your opinion, why are the Bassari so much worse off, compared to the other ethnic groups, in terms of water, education, health care, and agriculture?
21. What would happen if the mission was no longer here? Do you envision the mission staying here well into the future?
22. Have you helped organize the Bassari, with village case de santé or health committees?

#### INTERVIEW SCHEDULE BASSARI FETISHERS

1. What is a fetish?
2. How many kinds of fetishes are there?
3. Can fetishes make people ill or healthy? In what ways? How?
4. If a sick person were to seek treatment from a modern healer could this ruin the effects of a fetish?
5. What are the origins of the Bassari? Of people? Of the world?
6. Do people respect the fetishes as much now as in the past? Why? Why not?
7. Will Bassaris always have their fetishes and will they always believe so strongly in them?
8. Do you also do divination and how does this relate to the fetishes?
9. What is a totem? What is its significance in Bassari life and in health?
10. Can you please tell us about spirits and bad winds and how they can affect the health and well being of a person?

INTERVIEW SCHEDULE  
PUBLIC HEALTH MINISTRY PERSONNEL

1. Please tell me about your work, what are your responsibilities, who is your constituency, etc.?
2. How long have you been in this position with the Ministry of Public Health?
3. Where did you work before you were assigned here?
4. What are your impressions of the health situation in the region of Tambacounda, department of Kedougou, arrondissement of Salemata?
5. What are the most serious health problems facing the Bassari?
6. In your opinion what are the causes of these problems?
7. In terms of personnel are you in a position to request, for example, more nurses?
8. In your opinion, what are the responsibilities of the state nurses who run the health posts?
9. In your experience, do indigenous healers (*les tradi-praticienes*) and state healers ever work together or coordinate their efforts?
10. Can you tell me how your epidemiological statistics are generated? From what data? How were they collected?
11. In your opinion, what is the health situation of the Bassari people? How? Why?
12. What are some ways to improve the health situation of the Bassari?

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